# Neurology Therapies

**Please fax completed referral form to 972-473-7563**

## PATIENT DEMOGRAPHIC INFORMATION

Patient's name: _____ Date of birth: _____ Phone #: _____

Address: _____ City/State/Zip: _____

Allergies: _____ Weight: _____ Height: _____

## DIAGNOSIS & CLINICAL INFORMATION

**Diagnosis**: *(ICD 10 Code Required)*

☐ Amyotrophic Lateral Sclerosis, G12.21
☐ Guillain-Barré Syndrome G61.0
☐ Multifocal Motor Neuropathy, G61.81
☐ Other: _____
☐ Multiple Sclerosis, G35
☐ Chronic Inflammatory Demyelinating Polyneuropathy, G61.81
☐ Myasthenia Gravis (G70.00-G70.01), ICD 10_____

**Prior Failed Therapy:**

Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____
Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____
Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____

**Test Results:** Please attach copy for all items checked.

☐ Negative Hepatitis B virus (HBV) screening
☐ Meningococcal vaccination
☐ Nerve biopsy report
☐ Acetylcholine receptor (AChR) antibodies
☐ Pulmonary function test
☐ Other: _____
☐ Electromyography (EMG) and Nerve conduction velocity (NCV) tests
☐ Lumbar puncture test
☐ anti-GM1 antibodies
☐ ALS Functional Rating Scale-revised (ALSFRS-r)

**Please include copy of insurance card, most recent H&P or MD note, medication list, and lab results.**

## THERAPY ORDERED

| MEDICATION | DOSE | DIRECTIONS/DURATION |
|---|---|---|
| IVIG<br>☐ No brand preference<br>☐ Brand preferred: _____ | ☐ **0.4gm/kg:** _____mg<br>☐ **1gm/kg:** _____mg<br>☐ **Other:** _____mg | ☐ **INITIAL:** Infuse IV daily x ____ days<br>☐ **MAINTENANCE:** Infuse IV every ____ weeks x 1 year<br>☐ **OTHER:** _____ |
| Ocrevus® (ocrelizumab) | **INITIAL:** 300mg<br>**MAINTENANCE:** 600mg | ☐ **INITIAL:** Infuse 300mg IV at Weeks 0 and 2<br>☐ **MAINTENANCE:** Infuse 600mg IV every 6 months x 1 year |
| Soliris® (eculizumab) | **INITIAL:** 900mg<br>**MAINTENANCE:** 1200mg | ☐ **INITIAL:** Infuse 900mg IV weekly x 4 weeks<br>☐ **MAINTENANCE:** Infuse 1200mg IV every 2 weeks x 1 year |
| Radicava® (edaravone) | 60mg | ☐ **INITIAL:** Infuse IV daily x 14 days, followed by 14 days drug free<br>☐ **MAINTENANCE:** Infuse IV daily x 10 days in a 14-day period, followed by 14 days drug free x 1 year |
| Tysabri® (natalizumab) | 300mg | ☐ Infuse IV every 4 weeks x 1 year |
| OTHER: | | |
| OTHER: | | |

**Is patient currently receiving therapy above from another facility?** ☐ **NO** ☐ **YES** If yes, Facility Name: _____

## REFERRING PHYSICIAN INFORMATION

Physician Name: _____ Specialty: _____

Address: _____ City/State/Zip: _____

Office Contact: _____ Phone #: _____ Fax #: _____

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AIR Care
Allergy, Immunology & Respiratory Care
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