RELIANT SPECIALTY INFUSION

AIC Neurology #2 - General **Fax: 833-808-0833**

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

Medical Assessment

Diagnosis (ICD-10):

Uplizna

- ❑ G36.0 Neuromyelitis Optica
- ❑ Other: _____

Vyepti

- ❑ G43. ____ Migraine in adults
- ❑ Other: _____

Vyvgart & Ultomiris

- ❑ G70.00 Myasthenia Gravis (gMG) without acute exacerbation
- ❑ G70.01 Myasthenia Gravis (gMG) with acute exacerbation
- ❑ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy
- ❑ Other: _____

****Please include a demographics page, front and back of an insurance card, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis****

Allergies: _____

Pre-Medication Orders:

- ❑ APAP □ 325mg □ 500mg □ 650mg - PO 30 minutes before infusion
- ❑ Diphenhydramine □ 25mg □ 50mg – PO 30 minutes before infusion OR □ 25mg IVP □ 50mg IVP
- ❑ Alternate Oral Antihistamines: □ Cetirizine 10mg □ Loratadine 10mg □ Fexofenadine 60mg or □180mg
- ❑ Methylprednisolone □ 40mg IVP □ 125mg IVP or other _____ mg IVP
- ❑ Famotidine □ 20mg PO □ 40mg PO □ 20mg IVP □ 40mg IVP
- ❑ Ondansetron □ 4 mg IVP □ 4 mg PO

Labwork: _____ To be Drawn by: □ Infusion Clinic Referring Provider

Medication

Ultomiris (ravulizumab) (weight based dosing)

- ❑ Induction: 40-59kg: 2400mg IV week 0, followed by 3000mg IV week 2
- ❑ Induction: 60–99kg: 2700mg IV week 0, followed by 3300mg IV week 2
- ❑ Induction: 100kg or greater: 3000mg IV week 0, followed by 3600mg IV week 2
- ❑ Maintenance: **(circle one)**
  40-59kg: 3000mg IV every 8 weeks, **50-99kg**: 3300mg IV every 8 weeks, **100kg or greater**: 3600mg IV every 8 weeks
- ❑ **Maintenance Refills**: _____

Uplizna (inebilizumab - cdon)

- ❑ Induction: Uplizna 300mg IV at week 0 & 2
- ❑ Maintenance: Uplizna 300mg IV every 6 months
- ❑ **Maintenance Refills**: _____

Vyepti (eptinezumab-jjmr)

- ❑ Administer Vyepti □ 100mg OR □ 300mg IV every 3 months
- ❑ **Maintenance Refills**: _____

Vyvgart (efgartigimod alfa-fcab)

- ❑ Administer 10 mg / kg once weekly for ___ weeks with ___ weeks between treatment cycles.
- ❑ **Maintenance Refills: ___**

Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)

- ❑ Administer 1,008mg / 11,200 u SC once weekly for ___ weeks with ___weeks between treatment cycles.
- ❑ **Maintenance Refills: ___**

Physician Prescription Orders Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____Physician Name: _____

NPI #_____Physician Signature: _____***Date:*** _____