

Phone : 844-800-5377

Fax : 214-782-9155

NEUROLOGY (BIOLOGIC THERAPIES) RX ENROLLMENT FORM

PATIENT INFORMATION

Patient Name:		Date of Birth:	Gender:	
Home Phone:	Cell Phone:	Email:		
Address:		City:	State:	Zip:
Emergency Contact:		Emergency Phone:		

CLINICAL INFORMATION

Diagnosis (ICD-10) Code: _____

Patient Weight: _____ kg lbs

Patient Height: _____ cm in

Allergies: _____

Pharmacy to coordinate home health nursing visit and/or nursing training

PRESCRIBER INFORMATION

Prescriber Name: _____

DEA #: _____ NPI #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Person: _____

PRESCRIPTION INFORMATION

Vyvgart Has patient received Vyvgart? Yes No

Medication	Dose	Directions
For gMG diagnosis: Vyvgart Intravenous (IV) 400mg/20mL efgartigimod alfa-fcab	<input type="checkbox"/> For patient weighing < 120kg: 10mg/kg <input type="checkbox"/> For patient weighing ≥ 120kg: 1,200mg *Dose will be rounded to the nearest vial size available.	<input type="checkbox"/> Initial Directions: Dilute withdrawn calculated Vyvgart dose with 0.9% Sodium Chloride to make a total volume of 125mL. Administer IV over one hour once weekly x 4 weeks. <input type="checkbox"/> Subsequent Directions: Repeat cycle beginning 50 days after the 1st dose of the previous cycle (unless otherwise specified below). <input type="checkbox"/> Other: _____
For gMG diagnosis: Vyvgart Hytrulo subcutaneous (SC) 1,008mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6mL	Contents of 1 vial 5.6mL	<input type="checkbox"/> Initial Directions: Administer SC over approximately 30-90 seconds once weekly x 4 weeks. <input type="checkbox"/> Subsequent Directions: Repeat cycle beginning 50 days after the 1st dose of the previous cycle (unless otherwise specified below). <input type="checkbox"/> Other: _____
For CIDP diagnosis: Vyvgart Hytrulo subcutaneous (SC) 1,008mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6mL	Contents of 1 vial 5.6mL	<input type="checkbox"/> Directions: Administer SC over approximately 30-90 seconds once every week (on-going).

RN to monitor patient at minimum for 60 minutes post IV infusion and at minimum 30 minutes post SC infusion.

Soliris (eculizumab)	Meningococcal Vaccination Status:	Induction dose: <input type="checkbox"/> Induction Dose already completed. <input type="checkbox"/> Infuse 600mg IV weekly x 4 weeks. Begin maintenance dose 1 week later at week 5. <input type="checkbox"/> Infuse 900mg IV weekly x 4 weeks. Begin maintenance dose 1 week later at week 5. <input type="checkbox"/> Other: _____								
	<table border="1"> <tr> <th>MenACWY</th> <th>MenACWY Completion Date</th> </tr> <tr> <td>1st Dose</td> <td></td> </tr> <tr> <td>2nd Dose</td> <td></td> </tr> <tr> <td>Booster Date</td> <td></td> </tr> </table>		MenACWY	MenACWY Completion Date	1st Dose		2nd Dose		Booster Date	
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MenB	MenB Completion Date									
1st Dose										
2nd Dose										
Booster Date										
<input type="checkbox"/> Prescriber elects to continue with Soliris therapy before patient receives full meningococcal vaccination.** **Required: include documentation notes to include reasoning for not completing, plan and timeline to complete, and antibacterial drug regimen the patient will be taking until fully immunized.										

Directions:
 Prior to administration dilute dose in 0.9% Sodium Chloride as directed per manufacturer's guidelines.
 For adults: Administer over at least 35 minutes, but not to exceed 2 hours.
 RN to monitor patient at minimum for 60 minutes following administration.



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PRESCRIPTION INFORMATION

Medication	Dose and Directions	
Ultomiris (ravulizumab-cwvz)	Meningococcal Vaccination Status:	
	MenACWY	MenACWY Completion Date
	1st Dose	
	2nd Dose	
	Booster Date	
	MenB	MenB Completion Date
	1st Dose	
	2nd Dose	
	Booster Date	
	<input type="checkbox"/> Prescriber elects to continue with Ultomiris therapy before patient receives full meningococcal vaccination.** **Required: include documentation notes to include reasoning for not completing, plan and timeline to complete, and antibacterial drug regimen the patient will be taking until fully immunized.	
	Is patient transferring from eculizumab? <input type="checkbox"/> Yes <input type="checkbox"/> No *Patients switching from eculizumab, Ultomiris loading dose to start at next scheduled eculizumab dose.	
	Loading Dose: <input type="checkbox"/> Loading Dose already completed. <input type="checkbox"/> For patient weighing 40-59kg : Infuse 2,400mg IV x 1 dose. <input type="checkbox"/> For patient weighing 60-99kg : Infuse 2,700mg IV x 1 dose. <input type="checkbox"/> For patient weighing ≥ 100kg : Infuse 3,000mg IV x 1 dose. <input type="checkbox"/> Other: _____	
	Maintenance Dose: *Starting 2 weeks after Loading Dose <input type="checkbox"/> For patient weighing 40-59kg : Infuse 3,000mg IV every 8 weeks. <input type="checkbox"/> For patient weighing 60-99kg : Infuse 3,300mg IV every 8 weeks. <input type="checkbox"/> For patient weighing ≥100kg : Infuse 3,600mg IV every 8 weeks. <input type="checkbox"/> Other: _____	

Directions:
 Prior to administration, dilute dose in 0.9% Sodium Chloride as directed per manufacturer’s guidelines.
 Infusion rate to follow manufacturer guidelines based on patient weight.
 Flush IV line with 20mL of 0.9% Sodium Chloride post infusion.
 RN to monitor patient at minimum for 60 minutes following administration.

REQUIRED FOR HOME INFUSION RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.

IV Access	To be administered PERIPHERALLY, unless otherwise indicated. <input type="checkbox"/> PORT <input type="checkbox"/> PICC	
Flush Protocol for IV drug admin days only	<ul style="list-style-type: none"> 0.9% NaCl: 1-10mL IV before/after infusion, or PRN for line patency/SASH. Heparin 100 units/mL: 5mL IV (central) PRN for final flush. 	
Pre and Post Medications Please strikethrough if not required	To be given by mouth 30 minutes prior to infusion. May repeat every 4-6 hours as needed.	
	Diphenhydramine	25mg-50mg (max 100mg/day)
	Acetaminophen	325mg-650mg (max 3000mg/day)
	For subcutaneous patients only if requested by patient/nurse. Lidocaine 2.5%/Prilocaine 2.5% topical (may dispense Lidocaine 4%) to injection site(s) at least 1 hour prior to needle insertion.	
Anaphylaxis Protocol	To be given intramuscularly PRN severe allergic reaction. Call 911. May repeat x 1. <ul style="list-style-type: none"> Epinephrine 0.3mg (≥30kg/66lbs) 	
Diphenhydramine Please select only if needed for IVIG	To be given via slow IV push PRN for moderate – severe reaction. <input type="checkbox"/> 25-50mg *For IV Adult Patients only*	
Quantity and Refills	Dispense 1-month supply with 1-year refill unless indicated below. <input type="checkbox"/> Dispense 3-month supply with 1-year refill <input type="checkbox"/> Other: _____	
Additional Orders		

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

By signing this form and using this pharmacy’s services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

<input type="checkbox"/> May Substitute/Product Selection Permitted/Substitution Permissible	<input type="checkbox"/> Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute
Prescriber Signature _____	Prescriber Signature _____
Date _____	Date _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words “No Substitution” _____ **NY & Iowa** providers, please submit electronic prescription.

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