EPSRx A CarePartners Pharmacy Company | CarePartners Specialty Infusion

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	☐ **For patient weighing < 120kg:** 10mg/kg ☐ **For patient weighing ≥ 120kg:** 1,200mg *Dose will be rounded to the nearest vial size available.	☐ **Initial Directions:** Dilute withdrawn calculated Vyvygart dose with 0.9% Sodium Chloride to make a total volume of 125mL. Administer IV over one hour once weekly x 4 weeks. ☐ **Subsequent Directions:** Repeat cycle beginning 50 days after the 1st dose of the previous cycle (unless otherwise specified below). ☐ 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	☐ **Initial Directions:** Administer SC over approximately 30-90 seconds once weekly x 4 weeks. ☐ **Subsequent Directions:** Repeat cycle beginning 50 days after the 1st dose of the previous cycle (unless otherwise specified below). ☐ 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	☐ **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:

MenACWY	MenACWY Completion Date
1st Dose	
2nd Dose	
Booster Date	

MenB	MenB Completion Date
1st Dose	
2nd Dose	
Booster Date	

☐ 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.

Induction dose:

☐ Induction Dose already completed.

☐ Infuse 600mg IV weekly x 4 weeks.
Begin maintenance dose 1 week later at week 5.

☐ Infuse 900mg IV weekly x 4 weeks.
Begin maintenance dose 1 week later at week 5.

☐ Other: _____

Maintenance dose:

☐ Infuse 900mg IV every 2 weeks.

☐ Infuse 1,200mg IV every 2 weeks.

☐ Other: _____

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

Ultomiris
(ravulizumab-cwvz)

Dose and Directions

Meningococcal Vaccination Status:

MenACWY	MenACWY Completion Date
1st Dose	
2nd Dose	
Booster Date	

MenB	MenB Completion Date
1st Dose	
2nd Dose	
Booster Date	

☐ 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?

☐ Yes ☐ No

*Patients switching from eculizumab, Ultomiris loading dose to start at next scheduled eculizumab dose.

Loading Dose:

☐ Loading Dose already completed.
☐ For patient weighing **40-59kg:** Infuse 2,400mg IV x 1 dose.
☐ For patient weighing **60-99kg:** Infuse 2,700mg IV x 1 dose.
☐ For patient weighing **≥ 100kg**: Infuse 3,000mg IV x 1 dose.
☐ Other: _____

Maintenance Dose:

*Starting 2 weeks after Loading Dose

☐ For patient weighing **40-59kg:** Infuse 3,000mg IV every 8 weeks.
☐ For patient weighing **60-99kg:** Infuse 3,300mg IV every 8 weeks.
☐ For patient weighing ≥**100kg**: Infuse 3,600mg IV every 8 weeks.
☐ 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. ☐ PORT ☐ PICC

Flush Protocol
for IV drug admin days only

- 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.

- 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.

☐ 25-50mg *For IV Adult Patients only*

Quantity and Refills

Dispense 1-month supply with 1-year refill unless indicated below.
☐ Dispense 3-month supply with 1-year refill ☐ 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.

☐ May Substitute/Product Selection Permitted/Substitution Permissible
Prescriber Signature _____ **Date** _____

☐ Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute
Prescriber Signature _____ **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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