vitalcare of AUBURN HILLS

VITAL CARE OF AUBURN HILLS (0429)
Address: 1532 N Opdyke Road, Suite 700
City/State/Zip: Auburn Hills, Michigan 48326

NEUROLOGY REFERRAL ORDER FORM
Phone: (947) 886-4178
Fax: (947) 886-4655

Essential Data

To process the referral, please provide the following minimum information:

- ☐ Patient demographic information and any additional relevant clinical documentation (labs and tests)
- ☐ Copy of insurance card (front and back)
- ☐ History and physical documentation (including documentation of infection history and diagnosis, recent hospitalizations)
- ☐ Recent medication list, IV access information, and home health agency if applicable
- ☐ Currently received and/or prior filed therapies along with lengths of treatment and/or reason for discontinuation

Patient Demographics

Last Name:		First Name:		SSN:
Date of Birth:	Sex:	Height (cm):	Weight (kg):	
Allergies:				
Address:				
City:		State:	Zip:	
Home Phone:		Mobile Phone:		
Emergency Contact Name:		Emergency Contact Phone:		
☐ Other Diagnosis/ICD-10:		☐ Other Diagnosis/ICD-10:		
If unable to find diagnosis/ICD-10 code, please refer to ICD-10-CM (cdc.gov) for reference.				

Patient Insurance Information

Primary Insurance Name:	Secondary Insurance Name:
Policy Holder Name:	Policy Holder Name:
Relation to Policy Holder:	Relation to Policy Holder:
Member ID:	Member ID:
Group ID:	Group ID:

Prescription*

Medication	Dose/Strength	Directions
☐ Ocrevus (ocrelizumab)	300mg vial	☐ INITIAL: Infuse 300mg IV on day 1 and day 15 ☐ MAINTENANCE: Infuse 600mg IV once every 6 months (max duration of 1 year)
☐ Tysabri (natalizumab)	300mg vial	☐ Infuse 300mg IV every 4 weeks (max duration of 1 year)
☐ Briumvi (ublituximab)	150 mg vial	☐ INITIAL: ☐ 150mg IV infusion ☐ 450mg IV infusion at 2 weeks after first infusion ☐ MAINTENANCE: 450mg IV every 24 weeks (max duration of 1 year)
☐ Lemtrada (alemtuzumab)	12mg vial	☐ INITIAL: ☐ 12mg IV infusion for 5 consecutive days ☐ 12mg IV infusion for 3 consecutive days 12 months after first infusion
☐ Vyvgart (efgartigimod alfa)	400mg vial	☐ 10mg/kg (max dose 1200mg) IV once weekly for 4 weeks (max duration of 1 year)
☐ Vygart-Hytrulo (efgartigimod alfa and hyluronidase-QVFC)	180mg/2000units vial	☐ Administer 1,008mg/11,200 SQ weekly for 4 weeks (max duration of 1 year)
☐ Rystiggo (rozanolixizumab)	280mg vial	☐ <50kg: 420mg SQ once weekly for 6 weeks (max duration of 1 year) ☐ 50kg to 100kg: 560mg SQ once weekly for 6 weeks (max duration of 1 year) ☐ >100kg: 840mg SQ once weekly for 6 weeks (max duration of 1 year)
☐ Ultomiris (ravulizumab)	300mg vial 1,100mg vial	☐ INITIAL: Weight based dosing, infuse IV ☐ 40kg to 59kg: 2,400mg ☐ 50kg to 100kg: 2,700mg ☐ >100kg: 3,000mg ☐ MAINTENANCE: Weight based dosing, infuse IV 2 weeks after initial dose (max duration of 1 year) ☐ 40kg to 59kg: 2,400mg IV every 8 weeks ☐ 50kg to 100kg: 2,700mg IV every 8 weeks ☐ >100kg: 3,000mg IV every 8 weeks ☐ OTHER: _____
☐ Soliris (eculizumab)	300mg vial	☐ INITIAL: Infuse 900mg IV weekly for 4 weeks, followed by 1200mg IV for fifth dose 1 week later ☐ MAINTENANCE: Infuse 1200mg IV every 2 weeks (max duration of 1 year) ☐ OTHER: _____
☐ Uplizna (inebilizumab-cdon)	100mg vial	☐ INITIAL: 300mg IV followed by 300mg at 2 weeks ☐ MAINTENANCE: 300mg IV starting 6 months after first infusion (max duration of 1 year)
☐ Radicava (edaravone)	30mg vial	☐ INITIAL: 60mg IV daily for 14 days followed by 14-day infusion free period ☐ MAINTENANCE: 60mg IV daily for 10 days out of 14 followed by a 14-day infusion free period (max duration of 1 year)
☐ Vypeti (eptinezumab-jjmr)	100mg vial	☐ 100mg IV every 12 weeks (max duration of 1 year) ☐ 300mg IV every 12 weeks (max duration of 1 year)
☐ Leqembi (lecanemab-irmb)	200mg vial 500mg vial	☐ 10mg/kg IV every 2 weeks (max duration of 1 year) MRIs at baseline, prior to 5th, 7th, and 14th infusion
☐ Aduhelm (aducanumab-avwa)	170mg 300mg	☐ INTIAL IV every 4 weeks as follows: ☐ 1mg/kg infusion every 4 weeks for infusions 1 and 2 ☐ 3mg/kg infusion every 4 weeks for infusions 3 and 4 ☐ 6mg/kg infusion every 4 weeks for infusions 5 and 6 ☐ MAINTENANCE: Starting with infusion 7, infuse 10mg/kg every 4 weeks (max duration of 1 year)

Additional Management Orders*

Hydration Protocol: ☐ Per Pharmacy Protocol ☐ Per Provider Protocol _____	**Premedication Protocol** ☐ Per Pharmacy Protocol ☐ Per Provider Protocol _____	**Anaphylaxis Protocol:** ☐ Per Pharmacy Protocol ☐ Per Provider Protocol _____
Flush Protocol: ☐ Per Pharmacy Protocol ☐ Per Provider Protocol _____	**Labs Protocol:** ☐ Per Pharmacy Protocol ☐ Per Provider Protocol _____	Other: _____

**Product selection permitted unless dispense as written is checked or clearly written on order form.*
**Vials will be rounded to the nearest vial if appropriate unless clearly written to dispense dose as written from provider.*

Notes to Pharmacy

☐ First Dose to be given in home
☐ Skilled Nursing visits as required

Referring Provider Information

Ordering Provider's Name:		
NPI:	Specialty:	
Facility Name:		
Address:		
City:	State:	Zip:
Office Phone:	Office Fax:	
Dispense as Written		
Provider Signature:		Date:

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED