Neurology order form for biologic therapies

Optum

Optum Infusion Pharmacy Phone: _____ Fax: 877-542-9352 or _____

Care specialist Name: _____ Phone: _____

Patient information

☐ see attached ☐ PEDIATRIC (younger than 13 years or less than 45 kg in weight)

Patient first name: _____ Middle: _____ Last: _____

Gender: ○ M ○ F DOB: _____ Last 4 of SSN: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ ○ Home ○ Work ○ Cell Alternate Phone: _____ ○ Home ○ Work ○ Cell

Emergency contact: _____ Phone: _____ Relationship: _____

Insurance: Please attach copy of the front and back of insurance card(s).

Medical assessment

Primary diagnosis: ☐ ICD10 Code: _____ Diagnosis: _____

Weight **in kg only**: _____ Date weight (in kg) obtained: _____

Allergies: _____

Required documentation:

- Include with this order supportive documents of tried and failed therapies, a list of current medications, vaccination history, lab results, and clinical notes as relevant to this therapy.

- For Soliris and Ultomiris therapy, include documentation of meningococcal immunization dates, or clinical notes as to rationale for not completing, the plan for vaccination and the antibacterial drug regimen the patient will be taking until fully immunized.

☐ **Prescriber approves to proceed with therapy before the patient receives full meningococcal vaccination.**

Selecting this box confirms the prescriber considers the risks to this patient of postponing start of care until at least 2 weeks following full immunization against meningococcal serotypes A, C, W, Y, and B per ACIP guidance as outweighing the risk of serious infection. The prescriber is requesting start of therapy to proceed. The prescriber has counseled the patient on the risks and is providing the patient with a prophylactic antibacterial drug regimen as outlined in the REMS requirements.

☐ **Patient requires a first lifetime dose and is to receive the first dose in the home or Optum Ambulatory Infusion Suite.**

Medication prescriptions and orders

Medication	**Dose and directions** (Select or enter desired dose regimens.)
Eculizumab (Soliris) Refills x1 year	☐ INDUCTION: Soliris 600 mg IV once weekly for 4 weeks, then 900 mg for the 5th dose one week later, then 900 mg every 2 weeks thereafter. ☐ INDUCTION: Soliris 900 mg IV once weekly for 4 weeks, then 1,200 mg for the 5th dose one week later, then 1,200 mg every 2 weeks thereafter. ☐ INDUCTION: Soliris, Other (specify): _____ ☐ MAINTENANCE: Soliris ☐ 900 mg ☐ 1,200 mg ☐ other dose _____ IV once every 2 weeks or indicate here if other frequency _____ ☐ SUPPLEMENTAL: Soliris dose and timing _____ Prior to administration dilute dose in 0.9% Sodium Chloride to a final concentration of 5 mg / mL. For adults: Administer as an intravenous (IV) infusion over at least 35 minutes, but not to exceed 2 hours. For pediatrics: Administer IV over a 1 – 4 hour period, as tolerated. RN to monitor patient at minimum 60 minutes post infusion and to take a final set of vital signs before concluding visit.

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Medication prescriptions and orders

Medication	**Dose and directions** (Select or enter desired dose regimens.)
Ravulizumab-cwvz (Ultomiris) Refills x1 year	☐ LOADING DOSE based on patient weight following the below specifications: Patient weight 40 kg to 59 kg: Ultomiris 2,400 mg in 0.9% Sodium Chloride for a final volume of 48 mL. Administer IV over no less than 48 minutes as tolerated by the patient at a rate not to exceed 60 mL / hr x1 dose. Patient weight 60 kg to 99 kg: Ultomiris 2,700 mg in 0.9% Sodium Chloride for a final volume of 54 mL. Administer IV over no less than 36 minutes as tolerated by the patient at a rate not to exceed 90 mL / hr x1 dose. Patient weight 100 kg or more: Ultomiris 3,000 mg in 0.9% Sodium Chloride for a final volume of 60 mL. Administer IV over no less than 24 minutes as tolerated by the patient at a rate not to exceed 150 mL / hr x1 dose. ☐ MAINTENANCE DOSE based on patient weight following the below specifications. Administer IV 2 weeks following the Loading Dose and every 8 weeks, or indicate here if other frequency. _____ Patient weight 40 kg to 59 kg: Ultomiris 3,000 mg in 0.9% Sodium Chloride for a final volume of 60 mL. Administer IV over no less than 54 minutes and at a rate no more than 67 mL / hr, as tolerated by the patient. Patient weight 60 kg to 99 kg: Ultomiris 3,300 mg in 0.9% Sodium Chloride for a final volume of 66 mL. Administer IV over no less than 42 minutes and at a rate no more than 95 mL / hr, as tolerated by the patient. Patient weight 100 kg or more: Ultomiris 3,600 mg in 0.9% Sodium Chloride for a final volume of 72 mL. Administer IV over no less than 30 minutes and at a rate no more than 144 mL / hr, as tolerated by the patient. ☐ SUPPLEMENTAL, Ultomiris dose and timing: _____ ☐ OTHER, Ultomiris dose and schedule: _____
Efgartigimod alfa (Vyvgart) **For intravenous (IV) infusion** Refills x1 year.	☐ Vyvgart dose based on patient weight following the below specifications. Patient weight 120 kg or less: Vyvgart dose is 10 mg / kg. Dose will be rounded to the nearest vial size available. Patients weight over 120 kg: Vyvgart dose is 1,200 mg. Dilute Vyvgart dose in 0.9% Sodium Chloride to a final volume of 125 mL. Administer as an intravenous (IV) infusion over 1 hour. Administration Schedule (select one): ☐ Administer Vyvgart dose IV once weekly x 4 weeks to complete a 28-day cycle. Repeat cycle beginning 50 days after the first dose of the previous cycle. ☐ Other _____
Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo) **For subcutaneous (SC) injection** Refills x1 year.	☐ Vyvgart Hytrulo 1,008 mg and 11,200 units / 5.6 mL. RN to administer by slow subcutaneous push into the abdomen over 30 to 90 seconds using a single lumen needle set for subcutaneous infusion per specifications in product prescribing information. Administration schedule (select one): ☐ CIDP: administer Vyvgart Hytrulo subcutaneously once weekly. RN to administer by slow subcutaneous push into the abdomen over 30 to 90 seconds using a single lumen needle set for subcutaneous infusion per specifications in product prescribing information. ☐ MG: administer Vyvgart Hytrulo subcutaneously once weekly x 4 weeks to complete a 28-day cycle. Repeat cycle beginning 50 days after the first dose of the previous cycle. RN to administer by slow subcutaneous push into the abdomen over 30 to 90 seconds using a single lumen needle set for subcutaneous infusion per specifications in product prescribing information.

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Ancillary prescriptions and orders

Premedication (select below): Dispense PRN x1 year.

	Drug	Patient Type	Dose	Dispense detail	Directions
☐	**DiphenhydrAMINE**	Adult & Pediatric > 30 kg	50 mg (two 25 mg capsules or tablets)	Dispense 25 mg capsules or tablets #100	Administer orally 30 minutes prior to Biologic medication. May repeat once if symptoms occur.
		Pediatric 15 - 30 kg	25 mg (10 mL)	Dispense 2.5 mg / mL oral solution #120 mL (300 mg)	
		Pediatric < 15 kg	12.5 mg (5 mL)	Dispense 2.5 mg / mL oral solution #120 mL (300 mg)	
☐	**Acetaminophen**	Adult & Pediatric > 30 kg	325 mg	Dispense 325 mg tablets or 325 mg (10.15 mL) unit dose oral solution #100.	Administer orally 30 minutes prior to Biologic medication. May repeat once if symptoms occur.
		Pediatric 15 - 30 kg	160 mg (5 mL)	Dispense 160 mg (5 mL) tablets #30 or 32 mg / mL oral solution 120 mL.	
		Pediatric < 15 kg	80 mg (2.5 mL)	Dispense 32 mg / mL oral solution 120 mL.	
☐	**Other, specify** _____				

Lab Orders, x1 year	☐ CBC w/differential ☐ CMP ☐ Creatinine / BUN ☐ CRP ☐ ESR ☐ Other _____ Frequency of labs: _____ Lab work to be obtained via IV access using aseptic technique. If RN is not able to draw labs from a central catheter, the labs may be drawn peripherally. RN to flush IV access after each blood draw with 0.9% Sodium Chloride 20 mL. As a final lock for patency, use 5 mL of heparin 10 units / mL, or if for a port use 5 mL of heparin 100 units / mL.
Nursing Orders, x1 year	RN to complete assessment, administer therapy, and monitor patient per product prescribing information/ manufacturer guidelines. **Administration set flush:** When product labeling indicates upon completion of infusion administer 0.9% Sodium Chloride 50mL bag through the administration set at the same rate as the medication in an adequate amount to completely flush the tubing (20-30mL). **Peripheral:** RN to insert, maintain, and remove peripheral IV (PIVC) as needed using aseptic technique. Flush PIVC with Sodium Chloride 5 mL pre and post infusion. **Implanted Port:** RN to access port with non-coring needle using sterile technique and sterile field 0.9 % Sodium Chloride 10mL during needle changes. Flush port with 0.9% Sodium Chloride 10 mL pre and post infusion followed by final lock with Heparin 100 unit/mL 5mL. De-access port after infusion and flush with Heparin 100 unit/mL 5mL at least every 12 weeks to maintain patency. Discontinue port maintenance upon discontinuation of pharmacy services.
Pharmacy Orders, x1 year	Pharmacy to dispense flushes, needles, syringes and HME /DME quantity sufficient to complete therapy as prescribed.

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☑ **Anaphylaxis/infusion reaction management orders:** Dispense PRN x1 year

Drug	Patient Type	Dose	Dispense detail	Directions
DiphenhydrAMINE	Adult & Pediatric > 30 kg	50 mg (two 25 mg capsules or tablets)	Dispense 25 mg capsules or tablets #4	For mild* symptoms, slow infusion by 50% until symptoms resolve. Administer diphenhydrAMINE orally. For moderate* to severe* symptoms, stop infusion. Administer diphenhydrAMINE slow IV push not to exceed rate of 25 mg / minute. May repeat once if symptoms persist. For moderate* symptoms that resolve, resume infusion at 50% of the previous rate.
		50 mg (1 mL) injection	Dispense 50 mg vial for injection #1	
	Pediatric 15 - 30 kg	25 mg (10 mL) orally	Dispense 25 mg / 10 mL oral solution 120 mL	
		25 mg (0.5 mL)	Dispense 50 mg vial for injection #1	
	Pediatric < 15 kg	12.5 mg (5 mL) orally	Dispense 12.5 mg / 5 mL oral solution 120 mL	
		12.5 mg (0.25 mL)	Dispense 50 mg vial for injection #1	
EPINEPHrine	Adult & Pediatric > 30 kg	0.3 mg (0.3 mL) injection	Dispense 1 mg vial for injection #2	For severe* symptoms (anaphylaxis), stop infusion. Disconnect tubing from access device to prevent further administration. Activate 911. Administer EPINEPHrine IM into lateral thigh once. May repeat in 5 - 15 minutes if symptoms persist. Administer CPR if needed until EMS arrives. Contact prescriber to communicate patient status.
	Pediatric 15 - 30 kg	0.15 mg (0.15 mL) injection	Dispense 1 mg vial for injection #2	
	Pediatric 7.5 - 15 kg	0.1 mg (0.1 mL) injection	Dispense Autoinjector Pen 0.1 mg (PED) #2	
Other, specify				

*Mild symptoms include flushing, dizziness, headache, apprehension, sweating, palpitations, nausea, pruritus, and/or throat itching.
Moderate symptoms include chest tightness, shortness of breath, >20 mmHg change in systolic blood pressure from baseline, and/or increase in temperature (>2°F).
Severe symptoms include >40 mmHg change in systolic blood pressure from baseline, increase in temperature with rigors, shortness of breath with wheezing, and/or stridor.

Prescriber information

First Name: _____ Middle: _____ Last: _____ Practice: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ NPI: _____ Contact: _____

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

_____ _____ _____

Substitution permissible signature OR Dispense as written signature Date

Please fax: ☐ Completed form ☐ Demographic sheet/insurance information ☐ Clinical notes and labs

Please include ALL 4 pages of referral form and additional documentation when faxing.

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