NEUROLOGY

Version: 3/26/2025

PATIENT INFORMATION

Patient Name: DOB: Patient Phone:

Allergies: Weight lbs/kg: Height:

DIAGNOSIS

Diagnosis/ICD 10:

Documentation

- ◯ Demographic info, H&P, insurance info, labs results, 2-3 clinical visit notes (as appropriate)
- ◯ Premedications per pharmacy protocol
- ◯ Premeds: _____

IV line: ◯ Peripheral ◯ PICC ◯ PORT ◯ Other

Flushing Protocol: IV Line Flushing direction will be followed as per Mercy LTC & Specialty Pharmacy flushing protocol based on SASH/SAS technique With Normal Saline flushes and/or Heparin (10U/mL Or 100U/mL) based on IV line.

Skilled Nursing Care: Providing medication(s) via venous access or subcutaneous access in accordance with medication orders. Evaluation and documentation of health status, therapy response, and educational needs. Provide support and assistance as required.

MEDICATION	DOSE/STRENGTH	DIRECTIONS FOR USE	QTY	REFILLS
OCREVUS®	◯ 300 mg/10 mL vial	**Initial Dose:** ◯ Infuse 300 mg IV at week 0,2	**Initial:** #	
		Maintenance Dose: ◯ Infuse 600 mg IV 6 months after initial dose and every 6 months thereafter	**Maintenance** #	
KISUNLA®	◯ 350 mg/20 mL	**Initial Dose:** ◯ 700 mg IV every 4 weeks for 3 doses	**Initial** # 3	
		Maintenance Dose: ◯ Infuse 1400 mg IV every 4 weeks	**Maintenance** _____ weeks	
UPLIZNA®	◯ 100 mg/10 mL	**Initial Dose:** ◯ 300 mg IV at week 0, 2	**Initial** # 2	
		Maintenance Dose: ◯ Infuse 300 mg IV 6 months after initial dose and every 6 months thereafter	**Maintenance** #	
ULTOMIRIS	◯ 300 mg/30 mL (10 mg/mL) vial ◯ 300 mg/3 mL (100 mg/mL) vial ◯ 1,100 mg/11 mL (100 mg/mL) vial	**Initial Dose:** ◯ Infuse _____ mg IV once	**Initial** # 1	
		Maintenance Dose: ◯ _____mg IV every _____ weeks, start after 2 weeks from initial dose	**Maintenance**	

VYVGART	◯ IV: 400 mg/20 mL ◯ SQ: 400 mg/20 mL Vyvgart Hytrulo	◯ 10 mg/kg weekly for 4 weeks then subsequent treatment cycles based on clinical evaluation Diluted with 0.9% Sodium Chloride prior to administration	**Quantity** #	
OTHER				

PROVIDER INFORMATION

Disclaimer: Mercy LTC & Specialty Pharmacy and its representatives are authorized to provide medical necessity attestations, secure coverage, initiate the prior authorization process, and collect and submit lab results and other patient data as part of the authorization process as my authorized agent. This authorization is valid until revoked in writing by me. Mercy LTC & Specialty Pharmacy may also forward this information and any related materials related to the coverage of this product to the insurer's provider network if it cannot fulfill this prescription.

Provider/Practice Name: _____ Contact Person: _____

Provider NPI: _____ Phone: _____ Fax: _____

_____ _____ _____

Provider Signature **DAW (Dispense as Written)** **Date**

Confidentiality Statement: This referral form is intended solely for the use of the individual or entity to whom it is addressed. It contains confidential information that is protected by law. Unauthorized use, disclosure, or distribution of this form is strictly prohibited. If you have received this form in error or were not the intended recipient, please contact Mercy LTC & Specialty Pharmacy immediately at (562) 402-0542 and return or destroy all copies of the form.