

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
T (832) 500-3727 **F** (832) 500-8629 **E** specialty@hqrx.com

DATE: _____ NEXT TREATMENT DATE: _____

Please fax completed form along with copy of patient's insurance cards and any labs to **(832) 500-8629**

Patient Name _____ Phone _____ Date of Birth _____ Provider Name _____
 Practice Name _____ NPI# _____ Phone _____ Fax _____ Contact Person _____

MEDICAL INFORMATION

Patient: Wt. _____ Ht. _____ Allergies: Latex Other, specify _____

PRESCRIPTION

DIAGNOSIS	INFUSION ORDERS
<input type="checkbox"/> Migraines ICD-10: _____	Vyepeti: <input type="checkbox"/> 100mg IV every 3 months x1 year OR <input type="checkbox"/> 300mg IV every 3 months x1 year
<input type="checkbox"/> MS <input type="checkbox"/> Other: _____ ICD-10: _____	<input type="checkbox"/> Solu-Medrol 1gm IV daily x _____ day(s) OR <input type="checkbox"/> Solu-Cortef 1gm IV daily x _____ day(s)
<input type="checkbox"/> Diagnosis: _____ ICD-10: _____	Soliris: <input type="checkbox"/> 900mg IV weekly for the first 4 weeks, followed by 1200mg for the fifth dose 1 week later, then 1200mg every 2 weeks thereafter x1 year (initial start with maintenance) <input type="checkbox"/> 1200mg IV every 2 weeks x1 year (maintenance dosing)
<input type="checkbox"/> Multiple Sclerosis ICD-10: _____	<input type="checkbox"/> Tysabri 300mg IV every 4 weeks x1 year (after registering patient with TOUCH) <input type="checkbox"/> Ocrevus* <input type="checkbox"/> 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x1 year <input type="checkbox"/> 600mg IV every 6 months x1 year
<input type="checkbox"/> Diagnosis: _____ ICD-10: _____	IVIg Orders: _____ mg/kg OR _____ gm/kg IV divided over _____ day(s) Frequency: Every _____ weeks x1 year OR _____ one time dose only Preferred brand: _____ (HealthQuest to choose if not indicated)
<input type="checkbox"/> Diagnosis: Myasthenia Gravis ICD-10: _____	Vyvgart*: <input type="checkbox"/> 10mg/kg IV once weekly for 4 weeks (<120kg) <input type="checkbox"/> 1200mg IV over 1 hour once weekly for 4 weeks (≥120kg) *Cycle may be repeated >50 days from start of previous cycle. Subsequent cycles may be ordered as appropriate Rystiggo**: <input type="checkbox"/> <50kg: 420mg <input type="checkbox"/> 50kg to <100kg: 560mg <input type="checkbox"/> ≥100kg: 840mg subQ weekly x6 **Cycle may be repeated ≥63 days from start of previous cycle. Subsequent cycles may be ordered as appropriate

Pharmacist may substitute brand based on product availability. If needed, dose to be rounded to nearest whole vial.

Premedication orders: Tylenol 1000mg 500mg PO, please choose one antihistamine:
 Diphenhydramine 25mg PO Loratadine 10mg PO Cetirizine 10mg PO Quztytir 10mg IVP
Additional premedications: Solu-Medrol _____ mg IVP Solu-Cortef _____ mg IVP Other: _____
Lab orders: _____ **Frequency:** Every infusion Other: _____
 Yearly TB testing QFT (optional) Required labs to be drawn by: HealthQuest Referring physician

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
 - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5–10 minutes x1
 - 15–30kg (33–66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5–10 minutes x1
- Diphenhydramine: Administer 25–50mg orally OR IV (adult)
- NS 0.9% 500mL IV bolus as needed (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1–20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

I authorize HealthQuest Infusion & Specialty and its representatives to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above as well as selecting the preferred site of care for the patient. I understand that I can revoke this designation at any time by providing written notice to HealthQuest Infusion & Specialty.

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____

IMPORTANT NOTICE: This facsimile is intended to be delivered to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee.

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PATIENT INFORMATION

Patient Name _____ Date of Birth _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Include **signed** and **completed** order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes (H&P) to support primary diagnosis
 - Has the patient tried and failed previous drug therapy? Yes No
 - If yes, which drug(s)? _____
- Labs attached
 - JCV antibody (Tysabri orders)
 - AChR antibody (Rystiggo, Vyvgart) or MuSK antibody (Rystiggo)
 - Hepatitis B antigen and Hepatitis B core total (Ocrevus)
 - Serum immunoglobulins (Ocrevus)
 - Other supporting labs based on diagnosis/order
- Diagnostic testing
 - MRI documentation (Tysabri, Ocrevus)
 - Other diagnostic testing to support diagnosis/order
- Vaccine record
 - Meningococcal vaccinations - both Men B and Men ACWY (Soliris orders)
- Other medical necessity: _____

HealthQuest Infusion & Specialty will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please **fax** all information to **(832) 500-8629**