HealthQuest
Infusion & Specialty

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

NEUROLOGY REFERRAL FORM

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
☐ Migraines ICD-10: ______________	Vyepti: ☐ 100mg IV every 3 months x1 year OR ☐ 300mg IV every 3 months x1 year
☐ MS ☐ Other: ______________ ICD-10: ______________	☐ Solu-Medrol 1gm IV daily x ________day(s) OR ☐ Solu-Cortef 1gm IV daily x ________day(s)
☐ Diagnosis: ______________ ICD-10: ______________	Soliris: *(neuro dosing)* ☐ 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 (inital start with maintenance) ☐ 1200mg IV every 2 weeks x1 year (maintenance dosing)
☐ Multiple Sclerosis ICD-10: ______________	☐ Tysabri 300mg IV every 4 weeks x1 year (after registering patient with TOUCH) ☐ Ocrevus* ☐ 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x1 year ☐ 600mg IV every 6 months x1 year ☐ Briumvi (Ublituximab) ☐ Initial Dosing – First Infusion: 150mg IV; Second Infusion: 450mg IV administered 2 weeks after first infusion; Subsequent: 450mg IV at 24 weeks after the 1st infusion and q 24 weeks thereafter x1 year ☐ Maintenance Dosing: 450mg IV every 24 weeks x1 year
☐ Diagnosis: ______________ ICD-10: ______________	IVIg Orders: ________ mg/kg OR ________ gm/kg IV divided over ________ day(s) Frequency: Every ________ week(s) x1 year OR ________ one time dose only Preferred brand: ______________ (HealthQuest to choose if not indicated)
☐ Diagnosis: Myasthenia Gravis ICD-10: ______________	Vyvgart*: ☐ 10mg/kg IV once weekly for 4 weeks (<120kg) ☐ 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**: ☐ <50kg: 420mg ☐ 50kg to <100kg: 560mg ☐ ≥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 ☐ Quzyttir 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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COMPREHENSIVE SUPPORT FOR NEUROLOGY THERAPIES

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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, Briumvi)
- ☐ Serum immunoglobulins (Ocrevus, Briumvi)
- ☐ Liver function tests including bilirubin (Briumvi)
- ☐ 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**

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