Neurology
Patient Referral Form

Infusion Specialist
c:
e:

PATIENT INFORMATION

Date: Patient Name: Last 4 SSN DOB:

Address: City: ST: Zip:

Primary Phone: Work Phone:

Gender: ☐M ☐F Weight lbs/kg: Height: Allergies:

Primary Insurance: **Secondary Insurance:**

Member#: **Group#:** **Member#:** **Group#:**

Diagnosis: _____

Documentation needed: ☑ Insurance cards ☑ Most recent clinical including H&P ☑ Labs ☑ Diagnostic testing results

Medication	Order
Aimovig - Subcutaneous	☐ 70 mg once monthly ☐ 140 mg once monthly
Ajovy - Subcutaneous	☐ 225 mg sub-Q monthly ☐ 675 mg sub-Q every 3 months
Amprya (Dalfampridine) - Oral	☐ 10 mg PO twice daily ☐ Other:
Avonex - IM	☐ 30 mcg IM once weekly ☐ Other:
Copaxone (Glatiramer) - Subcutaneous	☐ 20 mg sub-Q daily ☐ 40 mg sub-Q three times per week
Gilenya - Oral	☐ 0.5 mg PO daily ☐ Other:
Kesimpta - Subcutaneous	☐ Initial: 20 mg week 0, week 1, week 2, then maintenance ☐ Maintenance: 20 mg sub-Q monthly (starting at week 4)
Ocrevus - IV	☐ Initial: 300 mg day 1 and day 15, then maintenance ☐ Maintenance: 600 mg every 6 months
Novantrone (Mitoxantrone) - IV	☐ 12 mg/m² IV every 3 months ☐ Other:
Radicava - IV	☐ Initial: 60 mg daily for 14 days ☐ Maintenance: 60 mg daily for 10 days out of 14; off 14 days. Repeat cycle
Rebif - Subcutaneous	☐ 22 mcg 44 mcg sub-Q three times weekly
Soliris - IV	☐ Initial: ☐ 600 mg ☐ 900 mg weekly x 4 weeks ☐ 900 mg ☐ 1200 mg week 5, then maintenance ☐ Maintenance: ☐ 900 mg ☐ 1200 mg every 2 weeks
Solumedrol (Methylprednisolone) - IV	☐ 500 mg ☐ 1000mg Other: Freq: Daily x _____ days
Tysabri - IV (Suite Only)	☐ 300 mg ☐ Freq: Every 4 weeks
Ultomiris - IV	☐ Initial: ☐ 2400 mg ☐ 2700 mg ☐ 3000 mg ☐ Maintenance (beginning 2 weeks after initial): ☐ 3000 mg ☐ 3300 mg ☐ 3600 mg every 8 weeks

FAX completed form to Axiva 844.440.0101 **Intake Specialist: 844.44-AXIVA (844.442.9482)**

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Vyepti - IV	☐ 100 mg ☐ 300 mg every 3 months
Vyvgart - IV	☐ 10 mg/kg (max 1200 mg) weekly for 4 weeks

Nursing

☑ Establish and/or maintain access device as needed for dose administration
☑ Administer by ordered route
☑ Obtain vital signs prior to, throughout as directed and at completion of infusion
☑ If reaction occurs follow procedure reaction management

PROVIDER INFORMATION

By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Axiva Health Solutions, Inc., has my permission to contact the patient's health plan to obtain authorizations necessary to enable it to receive payment for services.

Physician Name: NPI: DEA: License:

Address: City: ST: Zip:

Phone: Fax: Office Contact:

_____ _____ ♦ _____ _____

Physician Signature Required – Substitution Permitted Date Physician Signature Required – Dispense as Written Date