EAGLET PHARMACY

Neurology Infusion Referral Form

Toll Free Phone Number : 800-407-7421
Toll Free Fax Number : 800-308-8573

2209 SW 104th St Suite E, Oklahoma City, OK, 73159

This prescription form is to be sent & received via fax

Prescriber:		**NPI:**	
Supervising Physician:		**NPI:**	
Address:		**Tax ID:**	
Phone:		Fax:	
Contact:			

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ___/___/___	SS#: ___-___-___
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other:	Wt.: Ht.:

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment

Therapy Start Date	Date of Transplant	Date of Discharge	Date Medication Needed

Other/Concomitant Medications (please list)

Allergies ☐ NKDA ☐ Drug Allergies (please list) ☐ Other (please list)

Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained

ICD-10 Codes ☐ Kidney (Z94.0) ☐ Kidney/Pancreas (Z94.0/Z94.83) ☐ Heart (Z94.1) Lung (Z94.2) ☐ Heart/Lung (Z94.3) ☐ Liver (Z94.4) ☐ Bone Marrow (Z94.81) ☐ Intestines (Z94.82) ☐ Pancreas (Z94.83) ☐ B25 CMV disease ☐ B25.9 CMV disease, unspecified ☐ Other Code _____ Description _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Briumvi	☐ IV	☐ 150 mg	☐ Starting Dose - 150 mg on day 1, followed by 450 mg once 2 weeks later ☐ Maintenance Dose - 450 mg once every 24	3 Vials	0
☐ Immune Globulin	☐ SC ☐ IV ☐ IM	☐ _____ grams ☐ _____ grams	☐ 1 mg/kg/hr for first 30 minutes then increase every 30 minutes to a max rate of 6m/kg/hr not to exceed 300 ml/hr	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Lemtrada	☐ IV	☐ 12 mg/day	☐ Initial Dose – 12 mg/day over 4 hours for 5 consecutive days ☐ Maintenance Dose – 12 mg/day IV over 4 hours for 3 consecutive dates 12 months after initial dose		☐ 1 year ☐ _____
☐ Ocrevus	☐ IV	☐ 300 mg/10 mL vial	☐ Starter Dose – Infuse 300 mg iv over no less than 2.5 hours on day 1 and day 15 ☐ Maintenance Dose – Infuse 600 mg iv over no less than 3.5 hours every 6 months		☐ 1 year ☐ _____
☐ Vascular Access Method	☐ peripheral	☐ central	☐ other: _____		
☐ Normal Saline ☐ D5W	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ Before and after infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Heparin 10 units/mL ☐ Heparin 100 units/mL	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ After infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Diphenhydramine	☐ PO ☐ IV ☐ IM	☐ 25 mg ☐ 50 mg ☐ _____	☐ After infusion ☐ PRN Allergic Reaction: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Acetaminophen	☐ PO	☐ 325 mg ☐ 500 mg ☐ 650 mg ☐ 1 gm ☐ _____	☐ Pre-Med: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult 1:1000, 0.3 mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3 mL (15-30kg/33-66lbs)	☐ PRN Anaphylaxis ☐ Repeating Dose: _____	☐ Once ☐ _____	☐ 1 year ☐ _____
☐ Other:	☐ _____				

PRESCRIBER SIGNATURE

To Prescriber: By signing this form and utilizing our services, you are also authorizing Eaglet Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber: **Date:** ___/___/___

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.