



Jupiter Infusion
 140 Jupiter Lakes Blvd, Suite A
 Jupiter, FL 33458
 Office: 561-277-9211

Neurology Order Form

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 561-277-9226

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

THERAPY ORDER

Diagnosis	Infusion Orders
<input type="checkbox"/> Pompe Disease ICD-10: _____	<input type="checkbox"/> Lumizyme 20mg/kg IV every 2 weeks x 1 year <input type="checkbox"/> Nexviazyme 20mg/kg IV every 2 weeks x 1 year
<input type="checkbox"/> Acute Migraines ICD-10: _____	Premedication: <input type="checkbox"/> Zofran 4mg IVP <input type="checkbox"/> Zofran 8mg IVP <input type="checkbox"/> Pepcid 20mg IVP <input type="checkbox"/> Toradol 30mg IVP <input type="checkbox"/> Solu-Medrol 125mg IVP <input type="checkbox"/> Reglan 10mg IV <input type="checkbox"/> Benadryl 25mg IV Protocol: <input type="checkbox"/> Depacon 500mg <input type="checkbox"/> Depacon 750mg IV in 250mL NS <input type="checkbox"/> Magnesium Sulfate 1gm IV in 250mL NS <input type="checkbox"/> DHE 45 0.5mg <input type="checkbox"/> DHE 45 1mg IV in 100mL NS (must premed for nausea) Standing PRN Order: <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months Repeat regimen daily for _____ days
<input type="checkbox"/> Migraines ICD-10: _____	<input type="checkbox"/> Vyepiti <input type="checkbox"/> 100mg IV every 3 months x 1 year OR <input type="checkbox"/> 300mg IV every 3 months x 1 year <input type="checkbox"/> Robaxin <input type="checkbox"/> 1000mg IV every 2 weeks x 1 year OR <input type="checkbox"/> 1500mg IV every 2 weeks x 1 year
<input type="checkbox"/> MS <input type="checkbox"/> Other: _____ ICD-10: _____	<input type="checkbox"/> Solu-Medrol 1gm IV daily x _____ days <input type="checkbox"/> Solu-Cortef 1gm IV daily x _____ days
<input type="checkbox"/> Diagnosis: _____ ICD-10: _____	<input type="checkbox"/> Soliris <input type="checkbox"/> 900mg IV weekly for the first 4 weeks, followed by 1200mg for 5 th dose 1 week later, then 1200mg every 2 weeks thereafter x 1 year (initial start with maintenance) <input type="checkbox"/> 1200mg IV every 2 weeks x 1 year (maintenance dosing)
<input type="checkbox"/> Multiple Sclerosis ICD-10: _____	<input type="checkbox"/> Tysabri 300mg IV every 4 weeks (after registering patient with TOUCH program) <input type="checkbox"/> Ocrevus* <input type="checkbox"/> 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x 1 year (initial start with maintenance) <input type="checkbox"/> 600mg IV every 6 months x 1 year (maintenance dosing) <input type="checkbox"/> Briumvi* <input type="checkbox"/> 150mg IV x 1 dose, then 450mg IV 2 weeks later, then every 24 weeks (initial start with maintenance) <input type="checkbox"/> 450mg IV every 24 weeks x 1 year (maintenance dosing) *Premedication Protocol: Solu-Medrol 100mg IV and Benadryl 25mg PO/IV to be given 30 minutes before infusion
<input type="checkbox"/> Diagnosis: _____ ICD-10: _____	<input type="checkbox"/> IVIg Orders: _____ mg/kg OR _____ mg/kg IV divided over _____ day(s) Frequency: Every _____ weeks x 1 year OR _____ one time dose only Preferred Brand: _____ Active Infusions to choose if not indicated
<input type="checkbox"/> Myasthenia Gravis ICD-10: _____	<input type="checkbox"/> Ultomiris <input type="checkbox"/> Loading Dose: <input type="checkbox"/> 2400mg (40-59kg) <input type="checkbox"/> 2700mg (60-99kg) <input type="checkbox"/> 3000mg (>100kg) IV followed 2 weeks later by <input type="checkbox"/> Maintenance dose: <input type="checkbox"/> 3000mg (40-59kg) <input type="checkbox"/> 3300mg (60-99kg) <input type="checkbox"/> 3600mg (>100kg) IV every 8 weeks x 1 year <input type="checkbox"/> Vyvgart <input type="checkbox"/> 10mg/kg (<120kg) OR <input type="checkbox"/> 1200mg (>120kg) IV once weekly for 4 weeks
<input type="checkbox"/> hATTR amyloidosis ICD-10: _____	<input type="checkbox"/> Amvuttra 25 SubQ every 3 months x 1 year
Premedication orders: Tylenol <input type="checkbox"/> 1000mg OR <input type="checkbox"/> 500 mg PO Please choose one antihistamine: <input type="checkbox"/> Diphenhydramine 25mg PO / IV <input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Other: _____ Additional premedications: <input type="checkbox"/> Solu-Medrol _____ mg IVP <input type="checkbox"/> Solu-Cortef _____ mg IVP <input type="checkbox"/> Other: _____	

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Jupiter Infusion 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 assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____