Neurology

Referral Form

Please fax completed form to:
Fax: 386-385-7871
Phone 386-456-3000
AccordSpecialty@gmail.com

Ship To/Site of Care:	☐ In Office	☐ At Home	☐ Other (list):

PATIENT INFORMATION				PRESCRIBER INFORMATION			
Name:				Prescriber Name:			
Address:				Address:			
City, State, Zip:				City, State, Zip:			
Phone:		Weight (kg)		NPI AND License:			
Alt Phone:		Gender:		Office Contact:		Email	
DOB:		SSN:		Px:		Fax:	

CLINICAL INFORMATION			
Allergies:	☐ NKDA	☐ Allergies:	
Diagnosis:	ICD-10:	Condition:	Date of Diagnosis:

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Ref
☐ Briumvi	150 mg/6mL SDV	☐ Infuse 150 mg IV over 4 hours on day 1, followed by 450 mg IV over 1 hour 2 weeks later, then 450 mg IV every 24 weeks after initial dose ☐ MAINTENANCE: Infuse 450 mg IV over 1 hour every 24 weeks.		
☐ Imaavy	1,200 mg/ 6.5 mL SDV	☐ INITIAL: Infuse 30 mg/kg IV over 30 minutes as a single dose. ☐ MAINTENANCE: Infuse 15 mg/kg IV over 15 minutes once every 2 weeks.		0
☐ Kisunla	350 mg/ 20 mL SDV	☐ Infuse 350mg IV over 30 minutes at Week 0, 700mg IV at Week 4, 1,050mg IV at Week 8, followed by 1,400mg IV every 4 weeks thereafter ☐ MAINTENANCE: Infuse 1,400 mg IV every 4 weeks ☐ Other:		
☐ Ocrevus	300 mg/10 mL SDV	☐ Infuse 300mg IV on Day 1 & Day 15 (over at least 2.5 hours), then 600mg IV over 3.5 hours every 6 months after initial dose. ☐ MAINTENANCE: Infuse 600 mg IV over 3.5 hours every 6 months. If no prior serious infusion reactions, infusion can be given over 2 hrs.		
☐ Ocrevus Zunovo	920-23,000 units/23 mL SDV	Infuse 920-23,000 units SC over 10 minutes every 6 months.		
☐ Rituximab (Riabni, Rituxan, Ruxience, Truxima)	☐ 100 mg/10 mL ☐ 500 mg/50 mL ☐ Choice of brand per payer preference	☐ INITIAL: Infuse 1 g IV at weeks 0, 2. ☐ Infuse _____ mg IV every _____ for _____ doses ☐ Do not auto-substitute. Brand Preferred: _____		
☐ Tofidence, Tyenne (Actemra biosimilars)	☐ 200 mg/10 mL SDV ☐ 400 mg/ 20 mL SDV ☐ 80 mg/4 mL SDV ☐ Choice of brand per payer preference	Infuse 8 mg/kg IV over 1 hour every 4 weeks. ☐ Do not auto-substitute. Brand Preferred: _____		
☑ Tysabri	300 mg/15 mL SDV	Infuse 300 mg IV over 1 hour every 4 weeks.		
☐ Viltepso	250 mg/ 5mL SDV	Infuse 80 mg/kg IV over 60 minutes once weekly.		
☐ Vyepti	100 mg/mL SDV	☐ Infuse 100 mg IV over 30 minutes every 3 momths. ☐ Infuse 300 mg IV over 30 minutes every 3 months		
☐ Other (list)				

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies

PRESCRIBER SIGNATURE

By signing below, I certify that the above therapy is medically necessary and that the provided medical information is accurate to the best of my knowledge. I authorize Accord Specialty to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed. I understand that I can revoke this designation by providing notice to Accord.

Prescriber's Signature: _____ Date: _____