



NEUROLOGY ORDER SET

P: 888-386-0886 | F: 586-263-3306

PATIENT INFORMATION Fax completed form, insurance information and clinical documentation to 586-263-3306

Patient Name: _____ DOB: _____ Phone: _____
Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

Patient Weight: _____ lbs. (required) Allergies: _____
Lab orders: _____ **Frequency:** Each infusion Other: _____
 Required labs to be drawn by: Provider

THERAPY ORDER

Diagnosis	Infusion Orders
<input type="checkbox"/> Pompe Disease ICD-10: _____	<input type="checkbox"/> Lumizyme 20mg/kg IV every 2 weeks x1 year <input type="checkbox"/> Nexviazyme 20mg/kg IV every 2 weeks x1 year
<input type="checkbox"/> Diagnosis _____ ICD-10: _____	Soliris <input type="checkbox"/> 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 (initial start with maintenance) <input type="checkbox"/> 1200mg IV every 2 weeks x1 year (maintenance dosing)
<input type="checkbox"/> Multiple Sclerosis ICD-10: _____	<input type="checkbox"/> Tysabri 300mg IV every 4 weeks (after registering patient with TOUCH) <input type="checkbox"/> Ocrevus* <input type="checkbox"/> 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x1 year <input type="checkbox"/> 600mg IV every 6 months x1 year <input type="checkbox"/> Premed Protocol Solu-Medrol 100mg IV and Benadryl 25mg PO/IV to be given 30 minutes before infusion
<input type="checkbox"/> Diagnosis: _____ ICD-10: _____	IVIg Orders: _____ mg/kg OR _____ gm/kg IV divided over _____ day (s) Frequency: Every _____ weeks x1 year OR _____ one time dose only Preferred brand: _____ (Compassus to choose if not indicated)
Pre-medication Orders	<input type="checkbox"/> Tylenol 1000mg PO <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Benadryl 25mg PO <input type="checkbox"/> Benadryl 25mg IV <input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Solu-Medrol _____ mg IVP <input type="checkbox"/> Other _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing Compassus and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____
 Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____
 Opt out of Compassus selecting site of care (if checked, please list site of care): _____

PREFERRED LOCATION

City: _____ State: _____

Compassus

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PATIENT INFORMATION:

Patient Name: _____ DOB: _____

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?
If yes, which drug(s)? _____
- Labs attached
 - JCV antibody (Tysabri orders)
 - Hepatitis B antigen and Hepatitis B core total (Ocrevus)
 - Serum immunoglobulins (Ocrevus)
 - 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 & Ultomiris orders)
- Other medical necessity:

Compassus will complete insurance verification and submit all the 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 586-263-3306 or call 888-386-0886 for assistance

Compassus

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