# Neurology Order Form

*Specialty-specific infusion order form for neurology*

**REFERRING PROVIDER**

**PROVIDER NAME** | **NPI** | **DEA (IF CONTROLLED)** | **SPECIALTY**

**PRACTICE / CLINIC NAME** | **OFFICE PHONE** | **OFFICE FAX**

**OFFICE CONTACT NAME** | **CONTACT PHONE** | **CONTACT EMAIL**

**PATIENT INFORMATION**

**PATIENT LAST NAME** | **FIRST NAME** | **MIDDLE INITIAL**

**DATE OF BIRTH** | **SEX** | **PATIENT PHONE** | **BEST TIME TO CONTACT**

**ADDRESS** | **CITY, STATE, ZIP**

**INSURANCE**

**PRIMARY INSURANCE** | **MEMBER ID** | **GROUP #**

**SECONDARY INSURANCE (IF ANY)** | **MEMBER ID** | **GROUP #**

**DIAGNOSIS & CLINICAL JUSTIFICATION**

**PRIMARY DIAGNOSIS** | **ICD-10 CODE**

**SECONDARY DIAGNOSIS (IF APPLICABLE)** | **ICD-10 CODE**

**Common indications for this medication:** *Multiple sclerosis (G35), NMOSD (G36.0), myasthenia gravis (G70.0), CIDP (G61.81), Alzheimer's (G30), migraine (G43)*

**BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY**

**PRIOR THERAPIES TRIED AND OUTCOME**

**NEUROLOGY MEDICATIONS &MDASH; COMMONLY ORDERED**

*Ocrevus (ocrelizumab), Tysabri (natalizumab), Briumvi (ublituximab), Vyvgart (efgartigimod), Uplizna (inebilizumab), Leqembi (lecanemab), Kisunla (donanemab), Vyepti (eptinezumab), IVIG*

**MEDICATION ORDER**

**MEDICATION** | **GENERIC / ALT** | **STRENGTH / FORMULATION**

**DOSE** | **FREQUENCY** | **DURATION**

**ROUTE** | **PRE-MEDICATIONS (IF ANY)** | **SPECIAL INSTRUCTIONS**

**ANTICIPATED START DATE** | **# OF DOSES AUTHORIZED** | **SUBSTITUTION ALLOWED (Y/N)** | **BIOSIMILAR ACCEPTABLE (Y/N)**

**REQUIRED LABS & MONITORING**

Check all labs the prescriber requires Arbor to verify before each infusion:

- ☐ CBC w/ differential
- ☐ CMP
- ☐ Liver function panel
- ☐ Hepatitis B/C panel
- ☐ TB screen (T-SPOT or QFT)
- ☐ Pregnancy test (urine)
- ☐ Iron studies (ferritin, TSAT)
- ☐ Vitamin levels (B12, D, folate)
- ☐ Other (specify below)

**OTHER LABS / MONITORING REQUIREMENTS**

**PRESCRIBER SIGNATURE**

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Arbor Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

**PRESCRIBER SIGNATURE** | **PRINTED NAME** | **DATE**

*Form code: ARB-ORDER-NEUROLOGY · Submit to Arbor Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Arbor will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@arborinfuse.com*