Birmingham ID & Infusion

4704 Cahaba River Road, Suite 101-D, Birmingham. AL 35243

Phone (205) 739-2266 Fax (205) 490-8663 Bhaminfusion.com

VYEPTI (Eptinezumab-jjmr) Infusion Order

Patient Name _____ DOB _____

Phone _____ Patient Weight _____ Height _____

*Please attach demographics, clinic notes and labs (MIDAS, MPFID or HIT-6).

DIAGNOSIS (Please provide ICD-10 code):

_____ Migraine _____ _____ (Other)

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

_____ 100mg IV every three months _____ _____ (Other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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OCREVUS (Ocrelizumab) Infusion Order

Patient Name (Print) _____ DOB _____

Phone _____ Patient Weight _____

*Please attach demographics, clinic notes & labs (Hep B, Qgold or Chest X-ray).

DIAGNOSIS (Please provide ICD-10 code): _____

____ Multiple Sclerosis

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____ (other)

_____ Pepcid 20mg PRN _____ Benadryl 25-50mg PRN

OCREVUS ORDERS/DOSAGE:

_____ 300mg IV initial dose followed by a second 300mg IV dose after 2 weeks. Then subsequent doses every 6 months

_____ _____ (other)

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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TYSABRI (Natalizumab) Order

Patient Name _____ DOB _____

Phone _____ Patient Weight _____ Height _____

*Please attach demographics, clinic notes & labs (JVC antibody).

DIAGNOSIS (Please provide ICD-10 code):

_____ Multiple Sclerosis _____ _____Other

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

_____ 300mg infusion every 4 weeks _____ _____

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

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Infusion Order for Medication (Print) _____

Patient Name _____ Male____ Female____

DOB _____ Phone _____ Patient Weight _____

* Please attach demographics, clinic notes & labs.

DIAGNOSIS (Please provide ICD-10 code): _____

____ _____

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO _____ Solu-Cortef 100mg IVP _____ _____

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

___ _____

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____