Ascension at Home | TOGETHER WITH COMPASSUS®

NEUROLOGY ORDER SET

P: 414-563-0505 | F: 414-563-0600

PATIENT INFORMATION

Fax completed form, insurance information and clinical documentation to 414-563-0600

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
❒ Pompe Disease ICD-10: _____	❒ **Lumizyme** 20mg/kg IV every 2 weeks x1 year ❒ **Nexviazyme** 20mg/kg IV every 2 weeks x1 year
❒ Diagnosis _____ ICD-10: _____	**Soliris** *(neuro dosing)* ❒ 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) ❒ 1200mg IV every 2 weeks x1 year (maintenance dosing)
❒ Multiple Sclerosis ICD-10: _____	❒ **Tysabri** 300mg IV every 4 weeks (after registering patient with TOUCH) ❒ **Ocrevus*** ❒ 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x1 year ❒ 600mg IV every 6 months x1 year ❒ **Premed Protocol** Solu-Medrol 100mg IV and Benadryl 25mg PO/IV to be given 30 minutes before infusion
❒ 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: _____ (Ascension at Home to choose if not indicated)
Pre-medication Orders	❒ Tylenol 1000mg PO ❒ Cetirizine 10mg PO ❒ Benadryl 25mg PO ❒ Benadryl 25mg IV ❒ Loratadine 10mg PO ❒ Solu-Medrol _____ mg IVP ❒ Other _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing Ascension at Home together with 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 AAH together with Compassus selecting site of care (if checked, please list site of care): _____

PREFERRED LOCATION

City: _____ State: _____

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COMPREHENSIVE SUPPORT FOR NEUROLOGY THERAPY

P: 414-563-0505 | F: 414-563-0600

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:

  _____

Ascension at Home together with 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 414-563-0600 or call 414-563-0505 for assistance