

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List
- EMG Confirming MG • MG-ADL Assessment • Tried/Failed Therapies (including duration)

PRIMARY DIAGNOSIS

- G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
 G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
 Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: No recommended standard pre-meds for Rystiggo
 Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Dosing

- Weight <50kg: Rystiggo 420mg SubQ infusion once weekly for 6 weeks
 Weight 50kg to 99kg: Rystiggo 560mg SubQ infusion once weekly for 6 weeks
 Weight ≥100kg: Rystiggo 840mg SubQ infusion once weekly for 6 weeks
 Other: _____

Frequency

- One cycle only. (Provider to submit new referral when due for following cycle.)
 Repeat cycle every 28 days from last dose for 6 total cycles for one full year
 Repeat cycle every 28 days from last dose for _____ total cycles
 Other: _____

*Subsequent cycles to be administered no sooner than 63 days from start of previous treatment cycle.

First Dose: Y N

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per Curbside Infusion Policy and Procedure
 Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Anaphylaxis Protocol As Needed Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date