

Treatment Location: \_\_\_\_\_

**PROVIDERS: Please include the following to expedite the order:**

Patient Demographics, Most Recent Office Visit Note, Insurance Information, Recent Labs (AChR or MuSK antibody), List of Tried &amp; Failed Medications

**PATIENT INFORMATION**Referral Status:  New Referral  Updated Order  Order Renewal

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Patient Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

ICD-10 code (required):  Generalized Myasthenia Gravis  G70.00  G70.01 ICD Description: \_\_\_\_\_

Allergies: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height: \_\_\_\_\_

Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_**PROVIDER INFORMATION**

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**NURSING**

- Center will use Hypersensitivity protocol established by Infusion for Health and PI
- Tried & Failed Medications: \_\_\_\_\_
- AChR or MuSK Antibody Labs (Attach results) \_\_\_\_\_

**LABORATORY ORDERS**

- CBC  at each dose  every \_\_\_\_\_
- CMP  at each dose  every \_\_\_\_\_
- Other \_\_\_\_\_  every \_\_\_\_\_
- Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

**PRE-MEDICATION ORDERS***Pre-Medications not usually indicated.*

- Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

**SPECIAL INSTRUCTIONS:****THERAPY ADMINISTRATION**

- Rystiggo Subcutaneous Injection  
**Dosing According to Patient Weight:**
  - Less than 50kg / Dose: 420mg
  - 50kg to less than 100kg / Dose: 560mg
  - 100kg and above / Dose: 840mgRoute:  Subcutaneous Injection
- Frequency: Once weekly for 6 weeks
  - Additional Treatment Cycles: \_\_\_\_\_  
\*Subsequent cycles may require additional insurance authorization. \*Treatment cycles will be given 63 days from the start of the previous treatment cycle.
- Monitor patients for 15 minutes post-administration

*To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.*

Provider Name (Print) \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

- Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.