

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

- | | | | | |
|----------------------|-----------------------|--|---------------------|--------------------|
| 1. Insurance Card | 2. History & Physical | 3. Patient Demographics | 4. Most Recent Labs | 5. Medication List |
| 6. EMG Confirming MG | 7. MG-ADL Assessment | 8. Tried/Failed Therapies (including duration) | | |

PRIMARY DIAGNOSIS

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

LABS 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
<input type="checkbox"/> Weight <50kg: Rystiggo 420mg SubQ infusion once weekly for 6 weeks
<input type="checkbox"/> Weight 50kg to 99kg: Rystiggo 560mg SubQ infusion once weekly for 6 weeks
<input type="checkbox"/> Weight ≥100kg: Rystiggo 840mg SubQ infusion once weekly for 6 weeks
<input type="checkbox"/> Other: _____ | Frequency
<input type="checkbox"/> One cycle only. (Provider to submit new referral when due for following cycle.)
<input type="checkbox"/> Repeat cycle every 28 days from last dose for 6 total cycles for one full year
<input type="checkbox"/> Repeat cycle every 28 days from last dose for _____ total cycles
<input type="checkbox"/> Other _____ |
|---|--|

*Subsequent cycles to be administered no sooner than 63 days from start of previous treatment cycle. FIRST DOSE?: Yes No

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
 Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X _____ DATE _____
 PROVIDER SIGNATURE