

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 & 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 Infuse One Ohio
- Tried & Failed Medications: _____
- AChR or MuSK Antibody Labs (Attach results) _____

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, Infuse One Ohio is authorized to administer a generic or biosimilar.

Provider Name (Print)	Provider Signature	Date
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- Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.