



Please Fax Completed Form To: **888-340-3699**

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

Please Send a Copy of The Patient's Up-to-Date Clinical Notes

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION
<input type="checkbox"/> G70.00 Myasthenia gravis without (acute) exacerbation <input type="checkbox"/> G70.01 Myasthenia gravis with (acute) exacerbation <input type="checkbox"/> Other (ICD-10): _____ Diagnosis Description: _____
MG-ADL Score: _____ MGFA Classification: _____ AChR or MuSK antibodies: <input type="checkbox"/> Yes <input type="checkbox"/> No **Obtain the following labs at prior to start of treatment and at _____ frequency: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____

RYSTIGGO® ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Strength	Directions	Refills
Rystiggo® (Rozanolixizumab-noli)	<input type="checkbox"/> 280mg/2ml Vial <input type="checkbox"/> 420mg/3ml Vial <input type="checkbox"/> 560mg/4ml Vial <input type="checkbox"/> 840mg/6ml Vial	<input type="checkbox"/> (Body Weight of Patient <50kg): Administer 420mg via subcutaneous infusion once weekly for 6 weeks. Administer for _____ cycles based on clinical evaluation > 63 days from the start of previous cycle. <input type="checkbox"/> (Body Weight of Patient ≥ 50kg to <100kg): Administer 560mg via subcutaneous infusion once weekly for 6 weeks. Administer for _____ cycles based on clinical evaluation > 63 days from the start of the previous cycle. <input type="checkbox"/> (Body Weight of Patient ≥ 100kg): Administer 840mg via subcutaneous infusion once weekly for 6 weeks. Administer for _____ cycles based on clinical evaluation > 63 days from the start of previous cycle.	<input type="checkbox"/> 1 Year <input type="checkbox"/> _____

Pre-Medication	Dose/Strength	Directions
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg <input type="checkbox"/> 25mg	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Diphenhydramine	IV/PO <input type="checkbox"/> 50mg IV/PO <input type="checkbox"/> 40mg <input type="checkbox"/> 100mg	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR Inject <input type="checkbox"/> contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> Methylprednisolone	125mg _____	<input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed <input type="checkbox"/> Other: Inject 100mg IV 30 minutes prior to infusion
<input type="checkbox"/> _____	_____	_____

INFUSION REACTION ORDERS

Mild reaction protocol:

Diphenhydramine 25mg IV, one time, for pruritus.
If symptoms worsen, see orders for moderate to severe reactions.

Moderate reaction protocol:

Acetaminophen 650mg PO, one time, for pyrexia or rigors

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- Diphenhydramine 50mg IV, one time, for pruritus or urticaria
 - Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms
- If symptoms worsen, see interventions for severe reactions*
- Severe reaction protocol: (Call 911 if initiated):**
- Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)
 - Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
 - Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
 - Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms
 - Epinephrine 0.3mg/0.3mL IM into mid-antrolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline: <input checked="" type="checkbox"/> 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion	Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter: <input checked="" type="checkbox"/> 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw
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Locking Protocol (>66lbs/33kg)

PIV and Midline: <input checked="" type="checkbox"/> Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	PICC: <input checked="" type="checkbox"/> Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush	Implanted Port, Tunneled Catheter, and Non-tunneled Catheter: <input checked="" type="checkbox"/> Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush
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**** May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

SIGNATURE

We hereby authorize Infuse IQ LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____
Prescriber Signature

Date: _____

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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