

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"/> G70.0 Generalized Myasthenia Gravis (gMG) <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 MENINGITIS VACCINE: Patient HAS received first dose of both Conjugate (MenACWY) and Serogroup B (MenB) vaccines <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: _____

DRUG ORDERS			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____			
Medication	Dose/Strength	Directions	Refills
<input type="checkbox"/> Rystiggo® (Rozanolixizumab-noli)	<input type="checkbox"/> 280mg/2ml 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"/> _____

ANAPHYLACTIC REACTION (AR):
<input type="checkbox"/> EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> Diphenhydramine 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary <input type="checkbox"/> Methylprednisolone 40mg IVP <input type="checkbox"/> Sodium Chloride 0.9% 500 mL infuse IV at a rate of 30 mL/hr <input type="checkbox"/> Other: _____

SIGNATURE
X _____ Date: _____ <div style="text-align: center;">Prescriber Signature</div>

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