

**LAWRENCE COUNTY**  
**Memorial  Hospital**  
**DEACONESS ILLINOIS PARTNER**

| PATIENT INFORMATION   |   |  |
|---|---|--|
| Name:   | DOB:  |  |
| Allergies:  | Date of Referral:   |  |
| REFERRAL STATUS   |   |  |
| <input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal  |   |  |
| DIAGNOSIS AND ICDE 10 CODE  |   |  |
| <input type="checkbox"/> Myasthenia Gravis without (acute) exacerbation   | ICD 10 Code: G70.00   |  |
| <input type="checkbox"/> Myasthenia Gravis with (acute) exacerbation  | ICD 10 Code: G70.1 ____   |  |
| <input type="checkbox"/> Other: _____   | ICD 10 Code: _____  |  |
| REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)  |   |  |
| <input type="checkbox"/> The signed order form by the provider<br><input type="checkbox"/> Patient demographics AND insurance information<br><input type="checkbox"/> Prior authorization with reference number<br>Pt may be required to submit a pregnancy test prior to treatment | <input type="checkbox"/> Clinical/Progress notes (must be within 1 year)<br><input type="checkbox"/> Labs and tests supporting primary diagnosis<br><input type="checkbox"/> Confirmation of AchR antibodies or MuSK antibodies   |  |
| List of tried and failed therapies, including duration of treatment:<br>_____   |   |  |
| MEDICATION ORDERS   |   |  |
| Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____  |   |  |
| Dosing  | <input type="checkbox"/> J9333 Rystiggo 420mg SubQ inufison weekly for 6 weeks (patients weight less than 50kg)<br><input type="checkbox"/> J9333 Rystiggo 560mg SubQ weekly for 6 weeks (patients weight 50kg <100kg)<br><input type="checkbox"/> J9333Rystiggo 840mg SubQ infusion weekly for 6 weeks (patient weighting ≥ 100kg) |  |
| Duration: <input type="checkbox"/> None    Repeat for _____ cycle(s), subsequent cycle(s) start at ≥63 days from start of previous cycle  |   |  |
| PREMEDICATION/LABS  |   |  |
| <input type="checkbox"/> Acetaminophen _____ mg PO PRN  | <input type="checkbox"/> CBC  | <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ |
| <input type="checkbox"/> Benadryl _____ mg PO or IV   | <input type="checkbox"/> CMP  | <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ |
| <input type="checkbox"/> Methylprednisolone _____ slow IV push  | <input type="checkbox"/> Other: _____   | Date: _____  |
| <input type="checkbox"/> Other: _____   |   |  |
| ADDITIONAL ORDERS/INFORMATION   |   |  |
|   |   |  |
| PRESCRIBER INFORMATION  |   |  |
| Provider Name:  |   |  |
| Office Phone:   | Office Fax:   | Office Email:  |
| Prescriber Signature:   | Date:   | Time:  |

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515  
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

**INFUSION ORDERS – RYSTIGGO (rozanolixizumb-noli)**