Your Health, True Wealth

Myasthenia Gravis Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes, plus lab results for last 3 months, to:

f: 818-882-8929

PATIENT INFORMATION

Patient Name		DOB	Contact Phone
Address	City	State	Zip
Gender ☐ M ☐ F	Social Security, last 4 digits	Weight (lb.)	Height (in.)
☐ NKDA	☐ Allergies		
ICD-10 code (required)		ICD-10 description	
Patient Status: ☐ New to Therapy ☐ Previously Treated		AChR Results ☐ POS ☐ NEG	Meningococcal Vaccines ☐ Yes ☐ No

PRESCRIBER INFORMATION

Ordering Prescriber		Prescriber NPI	
Practice Name		Phone	Fax
Practice Address	City	State	Zip

REQUIRED DOCUMENTATION

☐ Insurance Cards ☐ History & Physical ☐ MGFA Classification and MG ADL ☐ Most Recent Labs ☐ Medication List

MYASTHENIA GRAVIS TREATMENT PLAN

☐ Ultomiris®
Loadingdose: Infuse _____mg IV
Maintenance dose: 2 weeks following the loading dose infuse _____mg every _____weeks

☐ Soliris®
Administer 900mg once weekly for 4 weeks, then give 1200mg at week 5. Then administer 1200mg IV every 2 weeksthereafter

☐ Vyvgart®
Administer 10mg/kg IV weekly over 1 hour weekly for 4 weeks

☐ Vyvgart Hytrulo®
Administer1008mg and 11200 units of hyaluronidase subcutaneously over 30 to 90 seconds weekly for 4 weeks

☐ Imaavy™
InitialLoading Dose: 30 mg/kg administered intravenously (IV)
Maintenance Dose: 15 mg/kg IV once every two weeks after the loading dose

☐ Rystiggo®
Administer ☐ (<50kg) 420mg ☐ (50kg-100kg) 560mg ☐ (100kg and above) 840mg once weekly for 6 weeks
Maintenance: Begin after clinical evaluation post-cycle at a frequency of _____ weeks from the last dose, and a dose of _____mg.

☐ Other — Include dosage, frequency and any other special instructions.

☐ Refill for 1 year

NURSING

Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medication administration, self-monitoring and safety.

PREMEDICATION

☐ Include premedication per Northridge Pharmacy Specialty & Infusion's infusion protocol.
☐ Other _____

LABORATORY ORDERS

☐ CBC every _____
☐ CMP every _____
☐ Other

I authorize the above patient treatment and Northridge Pharmacy Specialty & Infusion to serve as my agent when investigating and seeking approval of coverage and benefits for the Patient's services included in this form, including all site of service options and patient financial responsibility amounts. Such information may be provided to Northridge Pharmacy Specialty & Infusion at fax: 818-882-8929.

Prescriber Name (Print) _____ Prescriber Signature _____ Date _____