Rystiggo Infusion Order

LivWell INFUSIONS

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

◯ **G70.00 Myasthenia gravis without acute exacerbation**

◯ **G70.01 Myasthenia gravis with acute exacerbation**

Patients weight: _____

Lab Date: _____

Allergies: _____

MGFA Classification (I,II,III,IV,V): _____

MG-ADL Score: _____

Date of Assessment: _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

RYSTIGGO ORDER

AChR Antibody Test: ◯ Positive ◯ Negative ◯ Not Known

MuSK Antibody Test: ◯ Positive ◯ Negative ◯ Not Known

Patient Weight (kg): _____ **Date Weight Measured:** _____

Dosing:

◯ (Patient weight <50kg) 420mg (3mL) subcutaneous infusion once weekly for 6 weeks

◯ (Patient weight >50kg to <100kg) 560mg (4mL) subcutaneous infusion once weekly for 6 weeks

◯ (Patient weight >100kg) 840mg (6mL) subcutaneous infusion once weekly for 6 weeks

REFILLS: _____

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature _____ **Date:** _____