Myasthenia Gravis
REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 PHONE: +1(844) 650-5802

IV Solutions RX

1 PATIENTS INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE
Address: _____ **City/State/Zip:** _____
Primary Phone: _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____
Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____

2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

Primary Insurance: _____ **Policy No:** _____ **Group:** _____
Primary RX Insurance:_____ **ID No:**_____ **RX GRP:**_____ **RX BIN:**_____ **RX PCN:**_____

3 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10):

☐ G70.00 Myasthenia Gravis without (acute) exacerbation ☐ G70.01 Myasthenia Gravis with (acute) exacerbation
☐ Other Code: _____ Description: _____

Patient Clinical Information:

Drug Allergies:_____ ☐ NKDA Ht: _____in/cm Wt: _____lbs/Kg

Prior therapy, treatment dates, and reason(s) for discontinuation: _____
Treatment status: ☐ New to therapy ☐ Continuation of therapy; date of last treatment: _____/_____/_____
MG-ADL Score: _____ Date of assessment: _____/_____/_____
AChR Antibody Test: ☐ Positive ☐ Negative ☐ Not Known **MuSK Antibody Test:** ☐ Positive ☐ Negative ☐ Not Known

4 PRESCRIPTION INFORMATION

ACCESS: ☐ SUBCUTANEOUS

MEDICATION	STREGNTH	DOSING & DIRECTIONS	QUANTITY	REFILLS
☐ **VYVGART HYTRULO**	1008-11200/5.6mL	☐ **Loading Dose:** Administer 4 weekly injections subcutaneously over approximately 30 to 90 seconds.	4	~~0~~
		☐ **Maintenance Dose:** Administer next cycle _____ days after initial week 4 dose over approximately 30 to 90 seconds.	Q.S	(x1) Year

ACCESS: ☐ INTRAVENOUSLY ☐ PORT

☐ **Imaavy**	☐ 300 mg/ 1.62mL ☐ 1200 mg/ 6.5mL	**Initial Dose:** Infuse IV 30mg/kg *(Dose = _____mg)* over at least 30 minutes once.	Q.S	(x1) Year
		Maintenance Dose: Infuse IV 15mg/kg *(Dose = _____mg)* over at least 15 minutes every 2 weeks. **Start maintenance dose 2 weeks after the initial dose*	Q.S	(x1) Year

PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☐ Diphenhydramine **(PO)**	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**
☐ Acetaminophen **(PO)**	Administer _____ mg PO 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☒ EPINEPHRINE **(vial or autoinjector)**	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes ☐ ***0.3 mg (Wt > 30 kg)*** ☐ ***0.15 mg (Wt 15-30 kg)*** ☐ ***0.1 mg (Wt 7.5-15 kg)***	Quantity: **(x1) Vial** or **(x2) Pen(s)**	Refills: **PRN**
☒ DIPHENHYDRAMINE **(50mg/mL)**	Administer via IM or slow IV push for severe anaphylactic reaction. ☐ ***50 mg (Wt > 30 kg)*** ☐ ***25 mg (Wt 15-30 kg)*** ☐ ***12.5mg (Wt 7.5-15kg)***	Quantity: **(x1) Vial(s)**	Refills: **PRN**
☒ SODIUM CHLORIDE 0.9% **(IV)**	Infuse 500 mL IV as directed for severe anaphylactic reaction.	Quantity: **500 mL**	Refills: **PRN**

THERAPY SUPPLIES:

☐ **NURSING:** Nursing visits with each infusion to establish Subcutaneous or Intervenouse administer medication, assess and monitor patient, and provide education.
☐ **INFUSION SUPPLIES:** Infusion supplies, and infusion pump PRN for the reconstitution, administration, and disposal of medication.
FLUSHING PROTOCOL: ☐ Sodium chloride 0.9%, Up to 10 mL before/after medication, and/or PRN to maintain patency.
Heparin: ☐ 10 Units/mL ☐ 100 Units/mL, _____ as final flush and/or PRN to maintain patency

5 PRESCRIBER SIGNATURE REQUIRED *(STAMP SIGNATURE NOT ALLOWED)*

Prescriber Name: _____ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:** _____
Address: _____ **City/State/ZIp:** _____
Phone: _____ **Fax:** _____ **Contact Person:** _____

☐ **DISPENSE AS WRITTEN** ☐ **BRAND MEDICALLY NECESSARY** ☐ **DO NOT SUBSTITUTE**
☐ **NO SUBSTITUTION /** ☐ **DAW /** ☐ **MAY NOT SUBSTITUTE**
Prescriber's Signature: _____ **Date:** _____

☐ **May Substitute /** ☐ **Product Selection Permitted /** ☐ **Substitution Permissible**
Prescriber's Signature: _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.
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THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE *#welcome to our family*