Sarah Bush Lincoln

**NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.**

## PATIENT INFORMATION

| | |
|---|---|
| Name: | DOB: |
| Allergies: | Date of Referral: |

## REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

## INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

## Diagnosis and ICD 10 CODE

| | |
|---|---|
| ☐ Myasthenia gravis without (acute) exacerbation | ICD 10 Code: G70.00 |
| ☐ Myasthenia gravis with (acute) exacerbation | ICD 10 Code: G70.01 |
| ☐ Other ______________________________ | ICD 10 Code: ____________ |

## REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
☐ Most recent Clinical/Progress notes (must be within 1 year)
☐ Clinical/Progress notes supporting primary diagnosis

*Patient may be required to submit a pregnancy test prior to treatment

☐ Current Medication List
☐ Labs and test supporting primary diagnosis
☐ Confirmation of AchR antibodies or MuSK antibodies

List Tried & Failed Therapies, including duration of treatment:

1) ______________________________________________

2) ______________________________________________

## MEDICATION ORDERS

**Dosing Wt for Calculations** Ht: Wt (in kg): BMI:

**Dosing**

☐ J9333 Rystiggo 420mg subQ infusion weekly for 6 weeks (Patients weighing less than 50kg)
☐ J9333 Rystiggo 560mg subQ infusion weekly for 6 weeks (Patients weighing 50kg to <100kg)
☐ J9333 Rystiggo 840mg subQ infusion weekly for 6 weeks (Patients weighing ≥100kg)
☐ Other: ______________

**Duration** ☐ **None** ☐ **Repeat for ________ cycle(s), subsequent cycle(s) to start ≥63 days from start of previous cycle**

## ADDITIONAL ORDERS / INFORMATION

Lab Orders: ______________________________ Lab Frequency: ☐ Monthly ☐ Other: ______________

## PRESCRIBER INFORMATION

| | | |
|---|---|---|
| Prescriber name : | | |
| Office Phone: | Office Fax: | Office Email: |
| Prescriber Signature: | | Date: Time: |

**All information contained in this order form is strictly confidential and will become part of the patient's medical record.**

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr.
Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr.
Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499



**INFUSION ORDERS - RYSTIGGO (rozanolixizumab-noli)**

Clinics Scan to: Physician Orders