



Patient Information	
Name:	_____
DOB:	_____
Address:	_____
City:	_____ State: _____
Zip:	_____ Weight: _____
Phone:	_____
Allergies:	_____

Prescriber Information	
Prescriber Name:	_____
NPI:	_____
Address:	_____
City:	_____
State:	_____ Zip: _____
Phone:	_____

Diagnosis (please provide ICD-10 code in space provided):	
___ Myasthenia Gravis without (acute) exacerbation	___ Myasthenia Gravis with (acute) exacerbation
___ Other:	_____

**Nursing Orders: Hold infusion and notify provider for:**

Signs/symptoms of illness or active infection, planned/recent surgical procedures, cough, night sweats, unintended weight loss, recent live vaccinations, active shingles.  
If infusion related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Premedications:
<input type="checkbox"/> Tylenol 650mg PO <input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Benadryl 25mg IV or PO <input type="checkbox"/> Solu-Medrol 40mg, 125mg or ___ mg <input type="checkbox"/> Other: _____
Order valid for one year unless otherwise indicated. IV solutions and diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

<p>RYSTIGGO SQ</p>	<p>Dosing</p> <input type="checkbox"/> Weight < 50 kg: Rystiggo 420mg SubQ once weekly for 6 weeks <input type="checkbox"/> Weight 50 kg to 100 kg: Rystiggo 560mg SubQ once weekly for 6 weeks <input type="checkbox"/> Weight > 100 kg: Rystiggo 840mg SubQ once weekly for 6 weeks <input type="checkbox"/> Other: _____
	<p>Frequency</p> <input type="checkbox"/> One cycle only. (Provider to submit new order for subsequent cycle) <input type="checkbox"/> Repeat cycle for _____ total cycles <input type="checkbox"/> Other: _____
	<p>Subsequent cycles to start no sooner than 63 days from start of previous cycle.</p>

Prescriber Name (Please print): \_\_\_\_\_  
 Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please include a copy of the latest insurance information as well as all applicable clinical notes.**

Email to: orders@alliedinfusion.com Fax to: 832-698-3961