SOLEO HEALTH®
Simplifying Complex Care

# 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:
p: 844.503.0912 | f: 844.506.6185 | e: mgtherapy@soleohealth.com

## 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®
Loading dose: 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®
Administer 1008mg and 11200 units of hyaluronidase subcutaneously over 30 to 90 seconds weekly for 4 weeks

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

☐ Uplizna®
Initial Loading Dose: 300 mg IV for the first two doses given two weeks apart
Maintenance Dose: 300 mg intravenous infusion every six months

☐ 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 Soleo's infusion protocol.

☐ Other _____

## LABORATORY ORDERS

☐ CBC every _____
☐ CMP every _____
☐ Other

I authorize the above patient treatment and Soleo Health 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 Soleo Health at phone 844.575.1515, fax 844.797.5050, or email specialtyreferrals@soleohealth.com.

Prescriber Name (Print) _____ Prescriber Signature _____ Date _____