

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: 844.575.1515 | f: 844.797.5050 | e: specialtyreferrals@soleohealth.com

This form is not a valid prescription

-----✂----- Please detach before submitting to a pharmacy. Cut or tear here. -----

PATIENT INFORMATION

Patient Name		DOB	Contact Phone	
Address		City	State	Zip
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security, last 4 digits		Weight (lb.)	Height (in.)
<input type="checkbox"/> NKDA	<input type="checkbox"/> Allergies			Date
ICD-10 code (required)		ICD-10 description		
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Previously Treated		AChR Results <input type="checkbox"/> POS <input type="checkbox"/> NEG	Meningococcal Vaccines <input type="checkbox"/> Yes <input type="checkbox"/> No	

PRESCRIBER INFORMATION

Ordering Prescriber		Prescriber NPI		
Practice Name		Phone	Fax	
Practice Address		City	State	Zip

REQUIRED DOCUMENTATION

<input type="checkbox"/> Insurance Cards	<input type="checkbox"/> History & Physical	<input type="checkbox"/> MGFA Classification and MG ADL	<input type="checkbox"/> Most Recent Labs	<input type="checkbox"/> Medication List
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MYASTHENIA GRAVIS TREATMENT PLAN

<input type="checkbox"/> Ultomiris® Loading dose: Infuse _____mg IV Maintenance dose: 2 weeks following the loading dose infuse _____mg every _____weeks	<input type="checkbox"/> Soliris® Administer 900mg once weekly for 4 weeks, then give 1200mg at week 5. Then administer 1200mg IV every 2 weeks thereafter
<input type="checkbox"/> Vyvgart® Administer 10mg/kg IV weekly over 1 hour weekly for 4 weeks	<input type="checkbox"/> Vyvgart Hytrulo® Administer 1008mg and 11200 units of hyaluronidase subcutaneously over 30 to 90 seconds weekly for 4 weeks
<input type="checkbox"/> Imaavy™ Initial Loading Dose: 30 mg/kg administered intravenously (IV) Maintenance Dose: 15 mg/kg IV once every two weeks after the loading dose	<input type="checkbox"/> 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
<input type="checkbox"/> Rystiggo® Administer <input type="checkbox"/> (<50kg) 420mg <input type="checkbox"/> (50kg-100kg) 560mg <input type="checkbox"/> (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.	
<input type="checkbox"/> Other	Include dosage, frequency and any other special instructions.
<input type="checkbox"/> 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

<input type="checkbox"/> Include premedication per Pharmacy's infusion protocol.
<input type="checkbox"/> Other _____

LABORATORY ORDERS

<input type="checkbox"/> CBC every _____
<input type="checkbox"/> CMP every _____
<input type="checkbox"/> Other _____

The Pharmacy may contact the prescriber to comply with state-specific requirements. The prescriber is required to comply with any applicable state-specific prescription requirements (e.g., e-prescribing, prescription forms).

The information in this form is intended only for the person(s) or entity to which it is addressed and may contain confidential or legally protected material. If you receive this information in error, please contact the sender and destroy the document(s) promptly at the direction of the sender.