

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

PATIENT INFORMATION			
Name:		DOB:	
Allergies:		Date of Referral:	
REFERRAL STATUS			
<input type="checkbox"/> New Referral		<input type="checkbox"/> Dose or Frequency Change	
<input type="checkbox"/> Order Renewal			
INFUSION OFFICE PREFERENCES (Optional)			
Preferred Location* <input type="checkbox"/> Mattoon		<input type="checkbox"/> Effingham	
<small>*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.</small>			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Myasthenia gravis without (acute) exacerbation		ICD 10 Code: G70.00	
<input type="checkbox"/> Myasthenia gravis with (acute) exacerbation		ICD 10 Code: G70.01	
<input type="checkbox"/> Other _____		ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)			
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Most recent Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis <small>*Patient may be required to submit a pregnancy test prior to treatment</small>		<input type="checkbox"/> Current Medication List <input type="checkbox"/> Labs and test supporting primary diagnosis <input type="checkbox"/> Confirmation of AchR antibodies <u>or</u> MuSK antibodies	
List Tried & Failed Therapies, including duration of treatment:			
1) _____			
2) _____			
MEDICATION ORDERS			
<b>Dosing Wt for Calculations</b>		Ht:	Wt (in kg):
		BMI:	
<b>Dosing</b>	<input type="checkbox"/> J9333 Rystiggo 420mg subQ infusion weekly for 6 weeks (Patients weighing less than 50kg)		
	<input type="checkbox"/> J9333 Rystiggo 560mg subQ infusion weekly for 6 weeks (Patients weighing 50kg to <100kg)		
	<input type="checkbox"/> J9333 Rystiggo 840mg subQ infusion weekly for 6 weeks (Patients weighing ≥100kg)		
	<input type="checkbox"/> Other: _____		
<b>Duration</b>	<input type="checkbox"/> None <input type="checkbox"/> Repeat for _____ cycle(s), subsequent cycle(s) to start ≥63 days from start of previous cycle		
ADDITIONAL ORDERS / INFORMATION			
Lab Orders: _____		Lab Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> 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: SBL Infusion Center  
 Ph. 217-258-4150  
 217-342-7500  
 Fax Completed Form and all documentation to: Fax 217-342-7499