

Date Required: \_\_\_\_\_ Ship To:  Home  Office  Other: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Alternate Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_

**INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)**

Primary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
 Prescription Card: \_\_\_\_\_ ID: \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_

**To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:**

**DIAGNOSIS**

G70.0 Generalized Myasthenia Gravis (gMG)

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REMs Provider Enrollment Form Completed  
 Positive serologic test for anti-AChR antibodies  
 Documented meningococcal vaccine administration  
 Date Administered: \_\_\_\_\_  
 MG-ADL Score: \_\_\_\_\_  
 MGFA classification: \_\_\_\_\_  
 Current Medication List: \_\_\_\_\_  
 Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached  
 H&P  
 Labs/Tests  
 Patients Demographics, including insurance information  
 Please attach original prescription orders

**MEDICAL HISTORY**

Has patient previously received IVIG?  Yes  No  
 Is patient currently undergoing TPE?  Yes  No  
 Patient Weight: \_\_\_\_\_ kg  lbs Height: \_\_\_\_\_ cm  in  
 Allergies: \_\_\_\_\_  
 Line Access:  Peripheral  PICC  Port  
 Delivery Method:  Infusion Pump  Other: \_\_\_\_\_  
 Therapy Start Date: \_\_\_\_\_ Therapy End Date: \_\_\_\_\_  
 Nursing Coordination:  
 Pharmacy to coordinate home health nursing visit as necessary:  Yes  No  
 Home health nursing coordination not necessary. Reason:  
 MD office to administer to patient  
 Home health nursing already coordinated

**PRESCRIPTION INFORMATION**

Soliris Prescription:	Quantity/Weeks Supply:	Refills:
<input type="checkbox"/> For Treatment of gMG: <input type="checkbox"/> Dose Titration – Month 1: Administer 900 mg via IV infusion every 7 days for 4 weeks	4-week	0
<input type="checkbox"/> Maintenance Dosing: Administer 1,200 mg via IV infusion every 2 weeks starting Week 5	<input type="checkbox"/> 4-week <input type="checkbox"/> 12-week <input type="checkbox"/> Other: _____	1-year supply
<input type="checkbox"/> Other: _____	<input type="checkbox"/> _____	_____

**PREMEDICATION ORDERS/OTHER MEDICATIONS**

**Flush Protocol**

NaCl 0.9% 5ml  Heparin 10 units/ml  250ml 0.9% NaCl for hydration  
 NaCl 0.9% 10ml  Heparin 100 units/ml  Other: \_\_\_\_\_

**Pre-Medications & Other Medications**

Infusion supplies as per protocol  Acetaminophen \_\_\_\_\_ mg PO prior to infusion  
 Anaphylaxis Kit orders as per protocol  Diphenhydramine \_\_\_\_\_ mg PO

**ADDITIONAL COMMENTS:**

\_\_\_\_\_

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_