

 Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: Home Office Other: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Date of Birth: _____ Gender: _____
 Emergency Contact: _____ Phone: _____

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)
 G36.0 Neuromyelitis Optica Spectrum Disorder (NMOSD)

REMs Provider Enrollment Form Completed
 Documented meningococcal vaccine administration
 Date Administered: _____
 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

Positive serologic test for anti-AChR antibody for gMG
 Positive serologic test for anti-AQP4 antibody for NMOSD

MG-ADL Score: _____
 MGFA classification: _____

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
 Medications tried and failed: _____

PRESCRIPTION INFORMATION

Age Indication	Directions	Quantity: 300 mg/ml vials	Refills:
gMG Adults ≥ 18 yrs	Induction: 900 mg once weekly for 4 doses Maintenance: 1200mg at week 5, then 1200mg every 2 weeks thereafter.	4 weeks supply	_____
gMG Pediatrics patients < 18 yrs	≥ 40kg Induction 900 mg weekly for 4 doses Maintenance: 1200mg at week 5, then 1200mg every 2 weeks.	4 weeks supply	_____
	30kg to 40kg Induction: 600 mg weekly for 2 doses Maintenance: 900 mg at week 3, then 900 mg every 2 weeks.	4 weeks supply	_____
	20kg to < 30kg Induction: 600 mg weekly for 2 dose Maintenance: 600 mg at week 3, then 600 mg every 2 weeks.	4 weeks supply	_____
	20kg to < 30kg Induction: 600 mg weekly for 1 dose Maintenance: 300 mg at week 2, then 300 mg every 2 weeks.	4 weeks supply	_____
NMOSD	Induction: 900 mg weekly for 4 doses Maintenance: 1.2mg at week 5, then 1200mg every 2 weeks thereafter.	4 weeks supply	_____

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol NaCl 0.9% 5mL Heparin 10 units per mL Other: _____ NaCl 0.9% 10mL Heparin 100 units per mL	Premedications & Other Medications Infusion supplies as per protocol Acetaminophen _____ mg PO prior to infusion Anaphylaxis Kit orders as per protocol Diphenhydramine _____ mg PO
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ADDITIONAL COMMENTS:

Prescriber Signature: _____ **Date:** _____