

 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 ☐ G70.00 Myasthenia Gravis without (acute) exacerbation ☐ G70.01 Myasthenia Gravis with (acute) exacerbation ☐ Clinical/Progress notes with supporting diagnosis ☐ H&P ☐ Positive serologic test for anti-AChR antibody for gMG ☐ Positive serologic test for anti-MuSK antibody for gMG ☐ MG-ADL Score: _____ ☐ MGFA classification: _____ ☐ Patient's demographics, including insurance information ☐ Please attach original prescription orders ☐ Current medications: _____ Previous therapies: ☐ eculizumab ☐ rituximab ☐ IVIG ☐ oral corticosteroids ☐ non-steroidal ISTs ☐ Previous live vaccine: _____ Date: _____	MEDICAL HISTORY Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in Allergies: _____ 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		
Imaavy™ Pharmacy to determine appropriate number of vials to dispense prescribed dosage	Dose(s):	Refills:
☐ Initial Dose: 30mg/kg IV over at least 30 minutes	1	0
☐ Maintenance Dose: 15mg/kg IV over at least 15 minutes starting 2 weeks after the initial dose and every 2 weeks thereafter	2	12
30 minutes observation post each infusion		
ORDERS/OTHER MEDICATIONS		
▶ Orders are initiated: ▶ Infusion supplies as per protocol ▶ Anaphylaxis Kit orders as per protocol	Flush Protocol: ▶ NaCl 0.9% 10mL ▶ Before and after infusion ☐ Other: _____	
ADDITIONAL COMMENTS:		

Prescriber Signature: _____ **Date:** _____
