BluHaven HEALTH

Rystiggo Referral Form

Fax: (984) 370-2352
Phone: (984) 370-2350
Email: connect@bluhaven.com

Patient Information

Name: _____ DOB: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Weight: _____ ☐ lbs ☐ kgs

Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Most Recent Labs | Medication List | EMG Confirming MG | MG-ADL Assessment | Tried and Failed Therapies (including duration)

Primary Diagnosis

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)

☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)

☐ Other: _____

Order Information

Lab Orders (Include frequency)

Please list any labs to be drawn by the infusion clinic: _____

Pre-Medications

☑ Per infusion clinic protocol: No recommended standard pre-meds for Rystiggo.

☐ Provider Prescribed: _____

Primary Medication Order

Dosing

☐ Weight <50kg: Rystiggo 420mg subQ IV once weekly for 6 weeks

☐ Weight 50kg to 99kg: Rystiggo 560mg subQ IV once weekly for 6 weeks

☐ Weight ≥100kg: Rystiggo 840mg subQ IV once weekly for 6 weeks

☐ Other: _____

Frequency

☐ One cycle only. (Provider to submit new referral when due for following cycle.)

☐ Repeat cycle every 28 days from last dose for 6 total cycles for one full year

☐ Repeat cycle every 28 days from last dose for _____ total cycles

☐ Other: _____

**Subsequent cycles to be administered no sooner than 63 days from start of previous treatment cycle.*

First Dose: ☐ Yes ☐ No

Line Use/Care Orders

☑ Start PIV/ACCESS CVC

☑ Flush device per BluHaven Health's protocol (see BluHaven.com for policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box.

Adverse Reaction & Anaphylaxis Orders

☑ Administer acute infusion reaction and anaphylaxis medications per BluHaven Healths' protocol (see BluHaven.com for policy)

☐ Other: Please fax other reaction orders if checking this box.

Provider Information

Name: _____ Office Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

Provider Signature *Date*