

----- 3< AZ: Please detach before submitting to a pharmacy.

PATIENT INFORMATION				
Patient Name:		Caregiver (if applicable):		
Address:		City:	State:	Zip:
Main Phone:	Alternate Phone:	Email:	Last 4 of SSN (required):	
Date of Birth:	Male or Female	Height (required): _____ cm or inches	Weight (required): _____ lb or kg	
CLINICAL INFORMATION				
Primary ICD-10 Code:	Is patient currently on therapy? Yes No		Previous tried/failed therapies: Allergies:	
REQUIRED (Eculizumab, Ultomiris): Patient is up to date for meningococcal vaccinations (MenACWY & MenB)? Yes No Pending				
REQUIRED (ALL): Patient has positive serologic test for anti-AChR antibodies? Yes No Pending				
Please include face sheet, copy of insurance cards (front and back), H&P, clinicals and any available lab results.				
PRESCRIPTION AND ORDERS				
Medication	Dosing		Quantity	Refills
Eculizumab (Soliris®, Epsqli®, BKEMV®) (Adult gMG)	Induction: 900 mg IV once weekly x 4 weeks, then 1200 mg x 1 on week 5 Other: _____	Maintenance: 1200 mg IV every 2 weeks after induction Other: _____	5 doses for induction 4-week supply for maintenance Other: _____	x 1 year unless noted otherwise: ____refills
Ultomiris® (Adult gMG)	Induction: 40 kg to <60 kg: 2400 mg IV x 1 dose 60 kg to <100 kg: 2700 mg IV x 1 dose ≥100 kg: 3000 mg IV x 1 dose	Maintenance: (starting 2 weeks after induction dose) 40 kg to <60 kg: 3000 mg IV every 8 weeks 60 kg to <100 kg: 3300 mg IV every 8 weeks ≥100 kg: 3600 mg IV every 8 weeks Other: _____	1 dose for induction 8-week supply for maintenance Other: _____	x 1 year unless noted otherwise: ____refills
Vyvgart® (Adult gMG)	Initial Cycle: Weight <120 kg: 10 mg/kg IV once weekly x 4 weeks Weight ≥120 kg: 1200 mg IV once weekly x 4 weeks Other: _____	Maintenance: Additional cycle(s) after 50 days or more to be ordered after patient assessment. ____# of additional cycle(s) after 50 days or more Other: _____	4-week supply for initial cycle 4-week supply for additional cycle >50 days after initial cycle Other: _____	x 1 year unless noted otherwise: ____refills (begin no sooner than 50 days of the FIRST day of the previous infusion cycle).
Vyvgart® Hytrulo (Adult gMG) (Adult CIPD)	Initial Cycle: 1008 mg/11,200 units SUBQ once weekly x 4 weeks	Maintenance: Additional cycle(s) after 50 days or more to be ordered after patient assessment ____# of additional cycle(s) after 50 days or more 1008 mg/11,200 units SUBQ once weekly	4-week supply for initial cycle 4-week supply for additional cycle >50 days after initial cycle Other: _____ 4-week supply	x 1 year unless noted otherwise: ____refills (begin no sooner than 50 days of the FIRST day of the previous infusion cycle).
Medication Specific Infusion and Administration: Eculizumab - Administer over 35 minutes. Vyvgart IV® - Administer at a rate of 125 mL/hr.				
Ultomiris® - Administer using weight based rate per prescribing information. Vyvgart Hytrulo® - Administer SUBQ over 30-90 seconds.				
Labs:				
Flush Orders (IV infusions ONLY): Flush with 0.9% sodium chloride 5-10 mL pre and post medication and as needed, max per dispense x 60 syringes (refill x 1 year). For CVADs ONLY, may add Heparin 3-5 mL as final flush to maintain patency as needed; PORT 100 units/mL; PICC 10 units/mL, max per dispense x 30 syringes (refill x 1 year). Supplies: Dispense ancillary supplies, including ambulatory infusion pump (IV infusions ONLY), as needed to provide home infusion therapy.				
Premedication 30 minutes prior to infusion: Acetaminophen 500-1000 mg PO, dispense x 1 bottle (refill x 1 year) Diphenhydramine 25-50 mg PO, dispense x 1 bottle (refill x 1 year)		Adverse/Anaphylactic Reactions, per protocol (Subcutaneous): • Epinephrine autoinjector 0.3 mg IM as directed PRN for anaphylaxis, dispense 2pk x 1 (refill x 1 year)		
		Adverse/Anaphylactic Reactions, per protocol (Intravenous): dispense ana-kit x 1 (refill x 1 year) • Epinephrine 1:1000, 1 mL vial x 1 • Diphenhydramine 50 mg/1 mL vial x 1 • Diphenhydramine 50 mg tab/cap x 1 • 0.9% Sodium Chloride 500 mL bag x 1		
PRN: Ondansetron 4-8 mg slow IV push once as pre-med for nausea, then every _____ hours x _____ post-infusion (IV infusions ONLY), dispense x 2 doses (refill x 1 year) Ondansetron 4-8 mg PO once as pre-med for nausea, then every _____ hours x _____ (SUBQ ONLY), dispense x 2 doses (refill x 1 year)				Other:
Nursing Orders for Home Infusion: Provide skilled nursing for home medication administration as prescribed and per CSI nursing policies. Insert, access, and manage vascular access devices. Deliver nursing care for therapy duration and educate patient on medication, disease state, adverse reactions, and administration. Monitor patient response and report adverse events.				
PRESCRIBER INFORMATION				
Prescriber Name:		Practice site name:		
Address:		City:	State:	Zip:
NPI:	Phone:	Fax:		
Office contact and special instructions:				
Prescriber Authorization: I authorize the pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.				
Prescriber's Signature:			Date:	