

**PATIENT DEMOGRAPHICS**

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

**REQUIRED DOCUMENTATION**

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies

**PRIMARY DIAGNOSIS**

- G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
- G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
- Other: \_\_\_\_\_

**LAB ORDERS: PLEASE INCLUDE FREQUENCY**

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

**PRE-MEDICATIONS**

- Per infusion clinic protocol: No recommended premedications for Imaavy.
- Provider Prescribed: \_\_\_\_\_

**PRIMARY MEDICATION ORDER**

- Imaavy 30mg/kg (\_\_\_\_\_) IV on Day 1, then 15mg/kg (\_\_\_\_\_) IV every 2 weeks thereafter
  - Imaavy \_\_\_\_\_ mg every 2 weeks
  - Other: \_\_\_\_\_
- First Dose:  Y  N  Refill x12 months unless otherwise noted: \_\_\_\_\_

**LINE USE/CARE ORDERS**

- Start PIV/ACCESS CVC  Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other Flush Orders: Please fax other line care orders if checking this box

**ADVERSE REACTION & ANAPHYLAXIS ORDERS**

- Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other: Please fax other reaction orders if checking this box

**PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION**

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date