Myasthenia Gravis Enrollment Form (gMG)

Parkway SPECIALTY PHARMACY

3502 U.S. Highway 9. Howell. N.J. 07731 | www.**parkwaysp**.com | Email: intake@parkwaysp.com | Phone: 1-866-355-7797 | Fax: 1-888-551-6289

PATIENT INFORMATION

Name:	Date of Birth:	O Male O Female
Address:	City: State:	Zip:
Phone:	Alt Phone:	Email:
SS #:	Primary Language:	Emergency Contact:

PRESCRIBER INFORMATION

Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:	City:	State:	Zip:	Tax ID:
Phone:	Fax:			Office Contact:

PRESCRIPTION INFORMATION

Needs by Date: **Ship to:** **O Patients home** **O Prescriber 1st order only** **O Prescriber all orders** **O Other**

Drug	Dose	Direction & Quantities	Refills
O Intravenous Immunoglobulin	O 0.4 gm/kg O 1gm/kg O 2gm/kg O _____ grams	Infuse: O IV daily x _____ day(s); repeat every _____ week(s) x _____ cycles O Other: _____	
O Soliris	O 300 mg/30 mL vial (10 mg/mL)	O Dose Titration – Month 1: Administer 900 mg via IV infusion every 7 days for 4 weeks. 4 week-supply	0
		O Maintenance Dosing: Administer 1,200 mg via IV infusion every 2 weeks starting Week 5 O 4-week supply O 12-week supply O Other_____	1 - year supply
O Pre-medications:	O Acetaminophen 650mg PO 30 mins prior to infusion O Diphenhydramine 25mg PO 30 mins prior to infusion		
O Other:			
O Other Pre-medications:			

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

Patient Height:_____ in/cm Weight: _____ kg/lbs Allergies: _____ Bun/Creat.:_____

Diagnosis	**ICD-10**
Neuromuscular:	
O Myasthenia Gravis with (Acute) Exacerbation	G70.01
O Myasthenia Gravis (MG)	G70.0

Please Draw: O CBC/diff O CMP O IgG w/ subclasses 1-4 O Quant. Ig O _____ O _____ Frequency:_____

PER Anaphylaxis Protocol: *Administer intramuscularly in the event of ADR*

O Adult – EpiPen 0.3 auto-injector dual pack [May repeat x 1. Order is valid for 1 year]. **Use generic if applicable**

O Pediatric - EpiPen 0.15 auto-injector dual pack

If applicable, flush intravenous access device per Parkway Pharmacy protocol:

Access	**NS**	**Heparin 100 u/ml**
Peripheral	1-3ml before/after use	10u/ml 1-2mls after last NS flush
Midline, central (non-port), PICC	NS 5-10 mls before/after use; 10mls after blood draw	10 u/ml 3-5mls after last NS flush; 5mls after blood draw
Implanted Port	5-10mls before/after use; 20mls after blood draw	100 u/ml 5mls after last NS flush; 5mls after blood draw
Tunneled	5-10mls before/after use; 20mls after blood draw	10 u/ml 3- mls after last NS flush. 5mls after blood draw
Groshong PICC, Midline	5-10mls before/after use; 10mls after blood draw	NO Heparin needed

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: Date

CONFIDENTIALITY NOTICE

Faxed Prescriptions will only be accepted from a prescribing practitioner.