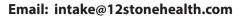
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





RYSTIGGO ORDER FORM						
Date:		ICD-10 Code:		Therapy Status		
Patient Name:		Allergies:		. -		
Date of Birth:				☐ Continuing Therapy:		
PROVIDER INFORMATION						
Ordering Provider:			Provider Fax:			
Provider NPI:			Provider Address:			
Provider Phone:						
MEDICATION ORDER						
☐ Weight less than 50kg: Infuse 420mg subcutaneously weekly for 6 weeks.					Places include the following lab we sulfe	
	☐ Weight 50kg to less than 100kg: Infuse 560mg so weekly for 6 weeks.				Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:	
Rystiggo	The Walland According and a basic lafter a CACord and automated and a configuration and the Cacordina					
I authorize additional cycles of treatment. Each subsequent cycle will be scheduled 63 days from the start of the previous treatment cycle, unless otherwise specified. The ordering of subsequent cycles of treatment should be based on clinical evaluation.					✓ Positive AChR or MuSK antibody result	
PRE-MEDICATIONS						
Oral IV						
☐ Acetaminophen:325mg500mg650mg			Dexamethasone:4mg8mg			
□ Loratadine: 10mg			☐ Diphenhydramine:25mg50mg			
□ Cetirizine: 10mg			☐ Famotidine:20mg40mg			
□ Diphenhydramine:25mg50mg			☐ Methylprednisolone: 125mg			
□ Famotidine:20mg40mg			☐ Hydrocortisone: 100mg			
□ Ibuprofen: 200mg400mg600mg			☐ Ondansetron:4mg8mg			
□ Ondansetron:4mg 8mg			Other:			
Other:						
LAB ORDERS (please indicate any labs to be drawn and frequency)			OTHER REQUIRED DOCUMENTATION			
			l '	(Please fax this signed order form, along with the following documents to 800-223-4063)		
			History & Physical, Last Office Visit Note			
			1	Patient Demographics and Insurance Information Medication List		
l l				• Recent Lab Work		
By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW) By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.						
Dispense as Written:			T	Substitution Allowed:		
Prescriber Sign	ature	 Date	Prescriber Sign	nature	 Date	