

RYSTIGGO

(rozanolixizumab-noli)



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
- EMG Confirming MG
- MG-ADL Assessment
- Tried/Failed Therapies (including duration)

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 standard pre-meds for Rystiggo.
- Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Dosing

- Weight <50kg: Rystiggo 420mg subQ once weekly for 6 weeks
- Weight 50kg to 99kg: Rystiggo 560mg subQ once weekly for 6 weeks
- Weight ≥100kg: Rystiggo 840mg subQ 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: Y N

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 _____