LIFE SPECIALTY SOLUTIONS

RYSTIGGO
(rozanolixizumab-noli)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card
2. History & Physical
3. Patient Demographics
4. Most Recent Labs
5. Medication List
6. EMG Confirming MG
7. MG-ADL Assessment
8. Tried/Failed Therapies (including duration)

PRIMARY DIAGNOSIS

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)

☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)

☐ Other _____

LABS 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 infusion once weekly for 6 weeks

☐ Weight 50kg to 99kg: Rystiggo 560mg SubQ infusion once weekly for 6 weeks

☐ Weight ≥100kg: Rystiggo 840mg SubQ infusion 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?: ☐ Yes ☐ No

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC

☑ Flush device per Real Medix - Real Infusions protocol (See realinfusions.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 Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)

☐ Other: (Please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE