Rozanolixizumab-noli (Rystiggo)

Provider Order Form rev. 10/04/2024

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Generalized Myasthenia Gravis:

Other: Description:

REQUIRED INFORMATION

Start of last Rystiggo cycle: ___________

Administer subsequent treatment cycles based on clinical evaluation; the safety of initiating subsequent cycles sooner than 63 days from the start of the previous treatment cycle has not been established.

THERAPY ADMINISTRATION & DOSING *(Choose one)*

☐ **Weight <50kg:** Administer Rystiggo 420mg (3ml) subcutaneously every week for 6 weeks

☐ **Weight 50kg - <100kg:** Administer Rystiggo 560mg (4ml) subcutaneously every week for 6 weeks

☐ **Weight 100kg+:** Administer Rystiggo 840mg (6ml) subcutaneously every week for 6 weeks

☑ Administer as subcutaneous infusion using approved infusion pump at a rate of up to 20 mL/hour

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every: _______

☐ CMP ☐ at each dose ☐ every: _______

☐ CRP ☐ at each dose ☐ every: _______

☐ Other: ______________________________

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: ______________________________

NURSING

☑ Hold infusion and notify provider for abnormal vital signs or signs/symptoms of infection or meningitis, new or worsening headache, or altered mental status

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, MGFA Classification, MG-ADL Score

Required Labs: AChR antibody, MuSK antibodies, CRP, ESR

Provider Name ***(print)*** **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.