Rozanolixizumab-noli (Rystiggo)

Provider Order Form rev. 07/30/2025

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.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.