Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:	
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Rystiggo® (rozanolixizumab-noli) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies: ☐ See list ☐ NKDA	

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	G70.00 - Myasthenia Gravis without acute exacerbation
☐	G70.01 - Myasthenia Gravis with acute exacerbation
☐	_____- Other:_____

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	MG-ADL Score/MGFA classification		☐ **Continue current order until insurance approved**
6	Positive AChR antibody		

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive rozanolixizumab-noli if receiving antibiotics for active infectious process, antifungal therapy, fever and/or suspected infection, and/or recent or planned surgery.

DOSE:

☑ Rystiggo® (rozanolixizumab-noli) administer the recommended dosage via subcutaneous infusion. Dosage based on the following guidelines from the FDA package labeling. Administer once weekly for 6 weeks (1 cycle).

Body Weight of Patient	*Dose*	*Volume to be Infused*
Less than 50kg	**420mg**	**3ml**
50kg to less than 100kg	**560mg**	**4ml**
100kg and above	**840mg**	**6ml**

FREQUENCY: (Select for additional treatment cycles)

☐ Patient to receive _____ cycles. Treatment cycles will be given 63 days from the start of the previous treatment cycle.

☐ OR, patient to receive _____ cycles. Repeat cycles _____ weeks from date of last infusion.

☐ Other:_____

Subsequent cycles may require additional insurance authorization

SPECIAL/LAB ORDERS:

☐ _____

☑ Refills x 12 months, if frequency is defined, unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	