

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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)

<input type="checkbox"/>	G70.00 - Myasthenia Gravis without acute exacerbation
<input type="checkbox"/>	G70.01 - Myasthenia Gravis with acute exacerbation
<input type="checkbox"/>	- Other: _____

REQUESTED DOCUMENTATION:

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

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



Checklist for referrals to Palmetto Infusion: Fax referral to 1.800.521.9640

- Patient demographics - address, phone number, SS#, etc.**
- Insurance information - copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com