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) 280mg/2mL administered via subcutaneous infusion at a max rate of 20mL/hr. 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

Follow each infusion with a (15) fifteen-minute post observation period.

SPECIAL/LAB ORDERS:

☐ _____

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

LINE USE/CARE ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Start PIV/Access CVC ☑ Flush device per facility standard flushing procedure	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	