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.

MEDICATION:

☑ Rystiggo® (rozanolixizumab-noli) administered via subcutaneous infusion at a max rate of 20mL/hr. Administer once weekly for 6 weeks (1 cycle).

DOSE:

☐ Dosage based on the following guidelines from the FDA package labeling.

Body Weight of Patient	*Dose*	*Volume to be Infused*
< 50 kg	**420mg**	**3ml**
50kg to100kg	**560mg**	**4ml**
>100kg	**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:

NURSING ORDERS:

☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

☑ Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adver reaction orders, which can be found at our website 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	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- [ ] **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