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

Rev. 4.29.25

PATIENT DEMOGRAPHICS:

Patient Name:			
Patient's Phone:		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 adverse reaction orders, which can be found at our website.

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	