

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

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	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	MG-ADL Score/MGFA classification	THERAPY:	
6	Positive AChR antibody		
			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.

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: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

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

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



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