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Rystiggo (Rozanolixizumab-noli) Subcutaneous Infusion Order

Patient Name: DOB: □ Male □ Female

Diagnosis (please provide ICD10 code):

□ Other:

□ NKDA □ Allergies:

□ New Therapy Order □ Continuation of Therapy Date of last dose:

Ordering Provider:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

Pre-Medication:

□ Acetaminophen _____mg by □ PO
□ Cetirizine _____mg by □ PO
□ Diphenhydramine _____mg by □ PO/ □ IVP
□ Solu-Medrol _____mg by □ PO/ □ IVP
□ Solu-Cortef _____mg by □ PO/ □ IVP
□ Other:

Rystiggo is a weight-based drug:

Patient Height (cm):

Patient Weight (kg):

Required Documentation:

□ Patient Demographics
□ Patient Insurance (med and pharm card copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□ AChR Antibody Test Result: _____
□ MuSK Antibody Test Result: _____
□ Brain MRI within one year
□ Tried and failed therapies
□ Other:

□ **Rystiggo Medication Order**

- Subcutaneous Dosage
  - □ Patients less than 50kg at the time of dosing, 420mg in 3mL
  - □ Patients 50kg to 100kg at the time of dosing, 560mg in 4mL
  - □ Patients more than 100kg at the time of dosing, 840mg in 6mL
  - □ Other: _____
- Frequency
  - □ Once a week for 6 weeks
  - □ Other: _____
- Refills (choose one)
  - □ None
  - □ Repeat for _____ cycles. Subsequent cycles start _____ days from day 1 of previous cycle.

Additional Instructions/Notes:

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Locations:

□ *Skokie, IL*: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
□ *Libertyville, IL*: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
□ *Orland Park, IL:* 16612 107th Ct, Ste B. P: 847-324-6800. F: 224-251-7141
□ *Houston, TX*: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400