Local Infusion

MYLOCALINFUSION.COM

RYSTIGGO (ROZANOLIXIZUMAB-NOLI) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Myasthenia Gravis (w/out acute exacerbation): G70.00

❑ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Rystiggo	❑ <50kg = 420mg/3ml ❑ 51-99kg = 560mg/4ml ❑ >100kg = 840mg/6ml	Subcutaneous Inj	1x week, for 6 weeks _____ cycles (subsequent cycles will be started no sooner than 63 days (~9 weeks) from the start of the previous cycle)

LABS / SPECIAL INSTRUCTIONS