Rystiggo® Order Form
(rozanolixizumab)

FAX TO: 972.499.9210

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F

Ht: _____ Wt: _____ ☐ lbs ☐ kg Primary Language: _____

Allergies: _____ Patient Preferred Location: _____

Diagnosis

ICD 10 Code Required

☐ Myasthenia Gravis without (acute) exacerbation (G70.00)
☐ Myasthenia Gravis with (acute) exacerbation (G70.01)
☐ Other: _____ ICD10 _____

Medication Order

DOSE | DIRECTIONS | DURATION

Pre-Medications
☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP
☐ Other: _____

Lab Orders
Requested Add'l Lab Orders:
_____
_____

Lab Frequency: _____every _____weeks

Infuse subcutaneously using a syringe infusion pump at a constant flow rate of 20 mL/hr once weekly x 6 doses
☐ 50kg: 420 mg
☐ 50kg to 99 kg: 560 mg
☐ ≥ 100 kg: 840 mg
May repeat above treatment cycle every _____ weeks x 1 year (no sooner than 63 days from the start of the previous cycle)
** Observe patient for 15 minues after completion of infusion**

Required Clinical Documentation

☐ Include signed and completed order (MD/prescriber to complete)
☐ Include patient demographic information and insurance information
☐ Include patient's current medication list
☐ Supporting clinical notes to include any past tried and|or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  ☐ Has the patient required 2 or more courses of plasmapheresis|plasma exchanges and|or intravenous immune globulin for at least 12 months without symptom control? ☐ YES ☐ NO
  ☐ Does patient have a hisory of abnormal nueromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation? ☐ YES ☐ NO
  ☐ Does the patient have a history of positive anticholinesterase test? ☐ YES ☐ NO
  ☐ Has the patient had documented contraindication|intolerance or failed trial of conventional therapy (i.e., pyridostigmine, immunosuppressants, corticosteroids, or acetylcholinesterase inhibitors) ☐ YES ☐ NO
  If yes, which drug(s)? _____
☐ Myasthenia Gravis Activities of Daily Living (MG-ADL) Score: _____
☐ Include labs and|or test results to support diagnosis
  ☐ AChR antibodies of MuSK antibodies **(required)**
☐ If ordering a subsequent treatment cyle, and patient is new to Medix Infusion, please indicate the start date of the last completed cycle: _____
☐ Other medical necessity: _____

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No
If yes, please note therapy and last dose:
_____

Medix Infusion will collect all necessary labs if not included in referral documents

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Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____