

# RYSTIGGO (ROZANOLIXIZUMAB-NOLI) ORDER FORM

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_  
 Allergies: \_\_\_\_\_

## 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     Famotidine 20 mg IV     Methylprednisolone (Solu-Medrol) 125 mg IVP  
 Benadryl 25mg PO     Cetirizine (Zyrtec) 10 mg PO  
 Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

## MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Rystiggo	<input type="checkbox"/> <50kg = 420mg/3ml <input type="checkbox"/> 51-99kg = 560mg/4ml <input type="checkbox"/> >100kg = 840mg/6ml	<input type="checkbox"/> Subcutaneous Inj	<input type="checkbox"/> 1x week, for 6 weeks

New Start Therapy     Continuation of Therapy    Date of last dose (if applicable): \_\_\_\_\_

## LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS:  NH: 603.217.5371     ME: 207.407.7272

Order valid for 1 year from date of signature unless otherwise specified here: \_\_\_\_\_