RYSTIGGO
(rozanolixizumab-noli)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- EMG Confirming MG
- MG-ADL Assessment
- Tried/Failed Therapies (including duration)

PRIMARY DIAGNOSIS

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Rystiggo
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Dosing
☐ Weight <50kg: Rystiggo 420mg SubQ infusion once weekly for 6 weeks
☐ Weight 50kg to 99kg: Rystiggo 560mg SubQ infusion once weekly for 6 weeks
☐ Weight ≥100kg: Rystiggo 840mg SubQ infusion once weekly for 6 weeks
☐ Other: _____

Frequency
☐ One cycle only. (Provider to submit new referral when due for following cycle.)
☐ Repeat cycle every 28 days from last dose for 6 total cycles for one full year
☐ Repeat cycle every 28 days from last dose for _____total cycles
☐ Other: _____

*Subsequent cycles to be administered no sooner than 63 days from start of previous treatment cycle.

First Dose: ☐ Y ☐ N

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals