Rozanolixizumab-noli (Rystiggo)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)

☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)

☐ Other:

PRIMARY MEDICATION ORDER

Rozanolixizumab-noli (Rystiggo), administer as a subcutaneous infusion

- Monitor patient during administration and for 15 minutes after completion for clinical signs and symptoms of hypersensitivity reactions
- Subsequent cycles to be administered no sooner than 63 days from start
- Order valid for 12 months unless otherwise noted: _____

DOSE	CYCLE FREQUENCY
☐ **Weight <50kg:** 420mg subQ once weekly for 6 weeks	☐ One cycle only. (Provider to submit new referral when due for following cycle.)
☐ **Weight 50kg to 99kg:** 560mg subQ once weekly for 6 weeks	☐ Repeat cycle every 28 days from last dose for 6 total cycles for one full year
☐ **Weight ≥100kg:** 840mg subQ once weekly for 6 weeks	☐ Repeat cycle every 28 days from last dose for _____ total cycles
	☐ Other: _____

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Rystiggo

☐ acetaminophen (Tylenol) ☐500mg / ☐650mg / ☐1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20 mg IV

☐ diphenhydramine (Benadryl) ☐25mg / ☐50mg ☐PO / ☐IV

☐ methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV

☐ Other: _____

Dose: _____ Route: _____

NURSING

- Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772

☐ Arbor Infusion Carmel (317) 981-1772