Rystiggo®

Provider Order Form Rev. 7/2024

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Myasthenia Gravis without (acute) exacerbation, G70.00

☐ Myasthenia Gravis with (acute) exacerbation, G70.01

☐ Other: _____, ICD10 _____

INFUSION ORDERS

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

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment:_____ Date of next treatment:_____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____

☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ NPI:_____ TIN:_____ Specialty:_____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ The patient is positive for anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibodies.

Please specify:

- ☐ Anti-acetylcholine receptor (AChR) antibody
- ☐ Anti-muscle-specific tyrosine kinase (MuSK) antibody

☐ The patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IV disease.

- Clinical Classification: _____

☐ The patient has a baseline MG-Activities of Daily Living (MG-ADL) score of ≥ 5.

- MG-ADL score: _____

LAB AND TEST RESULTS (required)

☐ Anti-acetylcholine Receptor (AChR) Antibodies

☐ Anti-muscle-specific tyrosine kinase (MuSK) Antibodies

☐ Baseline MG-Activities of Daily Living (MG-ADL) Evaluation Form

☐ Other: _____

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____