BioPlus® Infusion

Fax your completed order to 877-734-1157

Rystiggo (rozanolixizumab - noli) Order Form

PATIENT INFORMATION

Patient Name:_____ DOB:_____

Mobile Number:_____ Patient Weight:_____

Allergies:_____

DIAGNOSIS (Provider must specify:

❑ Myasthenia Gravis (w/out exacerbation): G70.00 (ICD10)

❑ 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

❑ Benadryl 25 mg PO ❑ Cetirizine (Zyrtec) 10 mg PO (Solu-Medrol) 125 mg IVP

❑ Other:_____ Dose:_____ Route:_____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Rystiggo	❑ <50 kg = 420mg/3ml ❑ <51-99 kg = 560mg/4ml ❑ >100kg = 840mg/6ml	❑ Subcutaneous Inj	❑ Weekly, x6 weeks

LABS / SPECIAL INSTRUCTIONS