Rozanolixizumab-noli (Rystiggo)

Provider Order Form *rev. 11/05/2025*

IVCARE INFUSION

☐ Nashville, TN

☐ Gallatin, TN

P: (615) 471-8673 F: (615) 471-8674

PATIENT INFORMATION

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

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

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

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per IVCare Infusion's Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVCare Infusion's Adverse Reaction Management Protocol available upon request

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ OTHER

PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500 mg ☐ 650 mg ☐ 1000 mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
Other: _____
Dose: _____ Route: _____

THERAPY ADMINISTRATION

☑ Rozanolixizumab-noli (Rystiggo)
☑ Dose
- Weight Less than 50kg: 420mg
- 50kg to less than 100kg: 560mg
- 100kg and above: 840mg

☑ Frequency: once weekly for six weeks (one treatment cycle)
☑ Route: subcutaneous infusion
☐ Select for additional treatment cycles.
_____ (Indicate number of cycles)
- Subsequent cycles may require additional insurance authorization.
- Treatment cycles will be given 63 days from the start of the previous treatment cycle.

☑ Administer as a subcutaneous infusion.
☑ Monitor patients during administration and for 15 minutes after completion for clinical signs and symptoms of hypersensitivity reactions. Order will expire one year from date signed.

CLINICAL INFORMATION (If available)

MG-ADL Score: _____ MGFA Classification: _____

AChR or MuSK antibodies: ☐ Yes ☐ No

MENINGITIS VACCINE:

Patient HAS received first dose of both Conjugate (MenACWY) and Serogroup B (MenB) vaccines ☐ Yes ☐ No

(If No, complete the following):

☐ Office will administer MenACWY and MenB Vaccines

☐ IVCare Infusion to Administer Meningococcal conjugate (MenACWY) Vaccine and Serogroup B Meningococcal (MenB) Vaccine: *Menactra OR Menveo - two doses separated by 8 weeks AND Bexsero - 2 doses separated by 1 month OR Trumenba - 3 doses at 0, 1-2 and 6 months. Vaccines will be given 2 weeks prior to starting Rystiggo infusion. If urgent Rystiggo administration is needed in unvaccinated patient, please contact us at (615) 471-8673*

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

Nashville Location : 5501A New York Avenue, Nashville. TN. 37209 **Gallatin Location : 710 Nashville Pike, Suite 103, Gallatin. TN. 37066**

Email info@ivcareinfusion.com or fax this Form, Insurance card (both sides), Demographics, Recent H&P, Labs & supporting Clinicals to:

FAX NUMBER FOR RYSTIGGO REFERRALS: (615) 471-8674