Rozanolixizumab-noli (Rystiggo)

Provider Order Form *rev. 1/25/2026*

IVCARE INFUSION

- ☐ Saint Cloud, FL
- ☐ Lake Mary-Sanford, FL
- ☐ Nashville, TN
- ☐ Gallatin, TN

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 separatedby 8 weeks AND Bexsero - 2 dosesseparatedby 1 month OR Trumenba - 3 doses at 0, 1-2and 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**

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

TN

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