



Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

| PATIENT INFORMATION (| Complete or Fax Ex | cisting Chart) | PRESCRIBER INFORMATION | | | | | |
|--|--|---|--------------------------------------|-------------------------------------|---------|--|--|--|
| Name: DOB: | | | Prescriber Name: | | | | | |
| | | | | | | | | |
| Address: City, State, Zip: | | | State License: | | | | | |
| Phone: Alt. Phone: | | | Address: | | | | | |
| | | | City, State, Zip: | | | | | |
| Email: SS#: (lbc) Little | | | Phone: Fax: | | | | | |
| Gender: M F Weight:(lbs) Ht: | | | Office Contact: Phone: | | | | | |
| Allergies | | | | | | | | |
| INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back) | | | | | | | | |
| Primary Insurance: | | | Secondary Insurance (If Applicable): | | | | | |
| Plan #: | | | Plan #: | | | | | |
| Group #: | | | Group #: | | | | | |
| RX Card (PBM): | | | RX Card (PBM): | | | | | |
| BIN: | PCN: | | BIN: | PCN: | | | | |
| CLINICAL INFORMATION | | | | | | | | |
| ☐ G70.0 Generalized Myasthenia Gravis (gMG) ☐ Other (ICD-10): Diagnosis Description: | | | | | | | | |
| MG-ADL Score: MGFA Classification: | | | | AChR or MuSK antibodies: ☐ Yes ☐ No | | | | |
| **Obtain the following labs at prior to start of treatment and at frequency: CBC CMP CRP ESR LFTs X-Ray Other: | | | | | | | | |
| RYSTIGGO® ORDERS | | | | | | | | |
| Prescription type: New start Restart Continued therapy Total Doses Received: Date of Last Injection/Infusion: | | | | | | | | |
| Medication | Dose/Strength | | D | irections | Refills | | | |
| Rystiggo® (Rozanolixizumab-noli) | ☐ 280mg/2ml Vial ☐ 420mg/3ml Vial ☐ 560mg/4ml Vial ☐ 840mg/6ml Vial | □ (Body Weight of Patient <50kg): Administer 420mg via subcutaneous infusion once weekly for 6 weeks. Administer for cycles based on clinical evaluation > 63 days from the start of previous cycle. □ (Body Weight of Patient ≥ 50kg to <100kg): Administer 560mg via subcutaneous infusion once weekly for 6 weeks. Administer for cycles based on clinical evaluation > 63 days from the start of the previous cycle. □ (Body Weight of Patient ≥ 100kg): Administer 840mg via subcutaneous infusion once weekly for 6 weeks. Administer for cycles based on clinical evaluation > 63 days from the start of previous cycle. | | | | | | |
| Pre-Medication | Dose/Strength | Directions | | | | | | |
| ☐ Acetaminophen | ☐ 500mg | ☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed | | | | | | |
| ☐ Diphenhydramine | ☐ 25mg IV/PO | ☐ Take 1 tablet PO prior to infusion or as directed OR | | | | | | |
| — ырпеннуаганнне | ☐ 50mg IV/PO | \square Inject contents of 1 vial IV prior to infusion or as directed | | | | | | |
| ☐ Methylprednisolone | □ 40mg□ 100mg□ 125mg | ☐ Inject contents of 1 vial IV prior to infusion or as directed ☐ Other: Inject 100mg IV 30 minutes prior to infusion | | | | | | |
| | | Section regest 100 mg 17 50 minutes prior to minusion | | | | | | |
| INFUSION REACTION ORDERS | | | | | | | | |
| Mild reaction protocol: | | | | | | | | |
| ☑ Diphenhydramine 25mg IV, one time, for pruritus. | | | | | | | | |
| If symptoms worsen, see orders for moderate to severe reactions. | | | | | | | | |
| Moderate reaction protocol: | | | | | | | | |
| . ☑ Acetaminophen 650mg PO, one time, for pyrexia or rigors | | | | | | | | |

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medicine as prescribed in this referral.



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| oximes Diphenhydramine 50mg IV, one time, for prurit | us or urticaria | | | | | | |
|--|--|--|---|--|--|--|--|
| ☑ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms | | | | | | | |
| If symptoms worsen, see interventions for severe re | eactions | | | | | | |
| Severe reaction protocol: (Call 911 if initiated): | | | | | | | |
| ☑ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%) | | | | | | | |
| ☑ Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis | | | | | | | |
| ☑ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis | | | | | | | |
| ☑ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms | | | | | | | |
| ☑ Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or | | | | | | | |
| worsen | | | | | | | |
| FLUSHING & LOCKING ORDERS | | | | | | | |
| Flushing Protocol (>66lbs/33kg) | | | | | | | |
| PIV and Midline: | | Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter: | | | | | |
| oximes 0.9% Sodium Chloride 2-5mL IV flush before and | d after each infusion | \boxtimes 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw | | | | | |
| Locking Protocol (>66lbs/33kg) | | | | | | | |
| PIV and Midline: | PICC: | | Implanted Port, Tunneled Catheter, and Non- | | | | |
| ☐ Heparin Sodium 10 units/mL 1mL IV final | ☑ Heparin Sodium 10 units/mL 3mL IV fina | | tunneled Catheter: | | | | |
| flush post normal saline flush | flush post normal saline | flush | ☐ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush | | | | |
| ** May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused | | | | | | | |
| SIGNATURE | | | | | | | |

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the

Prescriber Signature

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