Provider Order Form

RYSTIGGO (ROZANOLIXIZUMAB-NOLI)

Uptiv Health

PATIENT

Full Name: ______________________ DOB: ______________

Mobile Phone: ______________________ Weight: _______ ☐ lbs ☐ kg

Allergies: ______________________ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _________ Next Treatment Date: __________

DIAGNOSIS ICD-10 code (must be specified)

☐ Myasthenia gravis without (acute) exacerbation G70.00
☐ Myasthenia gravis with (acute) exacerbation G70.01
☐ Other: ______________________

PROVIDER

Provider Name: ______________________ Provider NPI: ______________________

Practice Name: ______________________ Referral Coordinator Name: ______________________

Practice Address: ______________________

Phone: ______________ Fax: ______________ Email: ______________________

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO	☐ 500 mg	☐ 650 mg	☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV	☐ 25 mg	☐ 50 mg	
☐ Methylprednisolone (Solu-Medrol) IV	☐ 40 mg	☐ 125 mg	
☐ Cetrizine (Zyrtec) 10 mg PO			
☐ Other: ______________			

THERAPY ADMINISTRATION

Medication	Body Weight	Dose	Frequency
☒ RYSTIGGO (Rozanolixizumab-Noli), SQ	☐ Less than 50 kg	☐ 420 mg	
	☐ 50 kg to less than 100 kg	☐ 560 mg	☐ Once weekly for 6 weeks.
	☐ 100 kg and above	☐ 840 mg	

Refills ☐ May repeat for ________ cycles (scheduled greater than 63 days from start of previous cycle)

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every ___________
☐ CMP	☐ at each dose	☐ every ___________
☐ CRP	☐ at each dose	☐ every ___________
☐ Other ______________	☐ at each dose	☐ every ___________

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics. ☐ Insurance card ☐ Progress Notes supporting DX. ☐ Positive AchR or MuSK antibodies test results

Provider Signature ______________________ Date ______________