TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

# RYSTIGGO®

**Please Fax Completed Form To: 888-898-9113**

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

Please Send a Copy of The Patient's Up-to-Date Clinical Notes

## PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

## PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____

NPI #: _____ Tax ID: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____ Phone: _____

## INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

## CLINICAL INFORMATION

☐ G70.00 Myasthenia gravis without (acute) exacerbation ☐ G70.01 Myasthenia gravis with (acute) exacerbation ☐ 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 | Directions | Refills |
|---|---|---|---|
| Rystiggo® (Rozanolixizumab-noli) | ☐ 280mg/2ml Vial<br>☐ 420mg/3ml Vial<br>☐ 560mg/4ml Vial<br>☐ 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.<br>☐ **(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.<br>☐ **(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. | ☐ 1 Year<br>☐ _____ |

| Pre-Medication | Dose/Strength | Directions |
|---|---|---|
| ☐ Acetaminophen | ☐ 500mg | ☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed |
| ☐ Diphenhydramine | ☐ 25mg IV/PO<br>☐ 50mg IV/PO | ☐ Take 1 tablet PO prior to infusion or as directed OR<br>☐ Inject contents of 1 vial IV prior to infusion or as directed |
| ☐ Methylprednisolone | ☐ 40mg ☐ 100mg<br>☐ 125mg | ☐ Inject contents of 1 vial IV prior to infusion or as directed<br>☐ Other: Inject 100mg IV 30 minutes prior to infusion |
| ☐ _____ | _____ | _____ |

## 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

TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

# RYSTIGGO®

**Please Fax Completed Form To: 888-898-9113**

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

Please Send a Copy of The Patient's Up-to-Date Clinical Notes

☒ Diphenhydramine 50mg IV, one time, for pruritus or urticaria

☒ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

*If symptoms worsen, see interventions for severe reactions*

**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:** |
|---|---|
| ☒ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion | ☒ 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-tunneled Catheter:** |
|---|---|---|
| ☒ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush | ☒ Heparin Sodium 10 units/mL 3mL IV final 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

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____

Prescriber 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.