immersiv HEALTH

RYSTIGGO® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: ______________________ **PHONE:** ______________

DATE OF BIRTH: ____________ **SEX:** ☐ M ☐ F **HEIGHT:** __________ **WEIGHT:** ____________ ☐ LBS ☐ KG

ALLERGIES: ______________________ **PREFERRED CLINIC:** ______________

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ G70.00 Myasthenia gravis w/o acute exacerbation (gMG)

☐ G70.01 Myasthenia gravis with acute exacerbation (gMG)

☐ ICD-10 CODE: __________ DESCRIPTION: ______________________

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Tried & failed Therapies ☐ Most recent History & Physical ☐ Positive AChR antibody (gMG)

☐ MG-ADL Score / MGFA classification (gMG)

MEDICATION ORDER

For Patients weighing ≤ 50 kg

☐ **CYCLE:** Rystiggo® (rozanolixizumab) 420 mg subcutaneously at max rate of 20 ml/hr once weekly for 6 weeks

For Patients weighing 50 kg to 100 kg

☐ **CYCLE:** Rystiggo® (rozanolixizumab) 560 mg subcutaneously at max rate of 20 ml/hr once weekly for 6 weeks

For Patients weighing ≥100 kg

☐ **CYCLE:** Rystiggo® (rozanolixizumab) 840 mg subcutaneously at max rate of 20 ml/hr once weekly for 6 weeks

Refills

☐ **Repeat cycle** ______ week(s) from date of last infusion; patient to receive a total of ______ cycles

Patient to be observed for 30 minutes following each infusion. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: ______________________ **NPI #:** ______________

EMAIL: ______________________ **PHONE:** ____________ **FAX:** ____________

ADDRESS (INCLUDE CITY, STATE, ZIP): ______________________

SUPERVISING PHYSICIAN: ______________________ **CONTACT NAME:** ______________
(IF APPLICABLE)

SIGNATURE: ______________ | ______________ **DATE:** ____________
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN