BioTek reMEDys®

RYSTIGGO®

Please Fax Completed Form To: **800-783-9146**

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

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

☐ G70.0 Generalized Myasthenia Gravis (gMG) ☐ Other (ICD-10): _____ Diagnosis Description: _____

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

Obtain the following labs at prior to start of treatment and at _____ frequency:

☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ LFTs ☐ X-Ray ☐ Other: _____

DRUG 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	☐ **(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.	☐ 1 Year ☐ _____

ANAPHYLACTIC REACTION (AR):

☐ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary

☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary

☐ Diphenhydramine 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary

☐ Methylprednisolone 40mg IVP

☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of 30 mL/hr

☐ Other: _____

SIGNATURE

X_____ Date: _____

Prescriber Signature