Rystiggo

Rozanolixizumab-noli

INFUSION FOR HEALTH
InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order.

Most Recent Office Visit Note, Medication List, Insurance Information, Labs (AChR or MuSK antibody labs)

☐ Tried and failed medications: _____

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: ☐ Generalized Myasthenia Gravis ☐ G70.00

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Pre-Medications: No pre-medications indicated.

☐ No Premeds

Center will use Hypersensitivity protocol established by Infusion for Health and P.I

DOSAGE

Date of Last Treatment, If Continuation:

Route: SubQ Injection

Frequency: Weekly x 6 weeks

Dosing According to Patient Weight:

	Body Weight of Patient	Dose	Volume to be Infused
☐	Less than 50kg	420mg	3mL
☐	50kg to less than 100kg	560 mg	4mL
☐	100kg and above	840mg	6mL

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.