

Los Angeles, CA
2080 Century Park East
Suite 710
Los Angeles, CA 90067



Rozanolixizumab-noli (Rystiggo)

Provider Order Form

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION
<input checked="" type="checkbox"/> Rozanolixizumab-noli (Rystiggo) in 0.9% sodium chloride <ul style="list-style-type: none">▪ Dose: Less than 50kg: 420mg▪ 50kg to less than 100kg: 560mg▪ 100kg and above: 840mg
<input checked="" type="checkbox"/> Frequency: once weekly for six weeks (one treatment cycle)
<input checked="" type="checkbox"/> Route: subcutaneous infusion
<input type="checkbox"/> Select for additional treatment cycles. _____ (Indicate number of cycles)
<ul style="list-style-type: none">▪ Subsequent cycles may require additional insurance authorization.▪ Treatment cycles will be given 63 days from the start of the previous treatment cycle.
<input checked="" type="checkbox"/> Administer as a subcutaneous infusion.
<input checked="" type="checkbox"/> Monitor patients during administration and for 15 minutes after completion for clinical signs and symptoms of hypersensitivity reactions. Order will expire one year from date signed.

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____