

Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830



Rozanolixizumab-noli (Rystiggo)

Provider Order Form

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS

☐ New Referral	☐ Referral Renewal	☐ Medication/Order Change	☐ Benefits Verification Only	☐ Discontinuation Order
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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

- ☐ **Rozanolixizumab-noli** (Rystiggo) in 0.9% sodium chloride
 - Dose: Less than 50kg: 420mg
 - 50kg to less than 100kg: 560mg
 - 100kg and above: 840mg
- ☐ Frequency: once weekly for six weeks (one treatment cycle)
- ☐ Route: subcutaneous infusion
- ☐ Select for additional treatment cycles.
_____ (Indicate number of cycles)
 - Subsequent cycles may require additional insurance authorization.
 - Treatment cycles will be given 63 days from the start of the previous treatment cycle.
- ☐ Administer as a subcutaneous infusion.
- ☐ 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 _____