TN
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ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

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

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 _____