McLeod Health

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Rozanolixizumab-noli (Rystiggo) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one):

☐ G70.00 Myasthenia Gravis without acute exacerbation ☐ G70.01 Myasthenia Gravis with acute exacerbation

☐ Other: ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders:

- Rozanolixizumab (Rystiggo) (J9333) administered via subcutaneous infusion at 20 ml/hr once weekly
- Dose: ☐ Weight < 50 kg: 420 mg (3 mL)
  ☐ Weight 50 kg-100 kg: 560 mg (4 mL)
  ☐ Weight > 100 kg: 840 mg (6 mL)
- Order Duration: Six weeks unless otherwise specified (Other: _____)

Standing Orders:

- Monitor patient for 15 minutes following completion of infusion. No flushing of infusion line following infusion completion.
- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Approved:

Pre-Screening Requirements:

● Positive anti-acetylcholine receptor (AChR) or anti-muscle-specific tyroskine kinase (MuSK) antibody

Previous Therapies:

● For new patient referrals, please send history and physical and most recent physician note with completed plan

● If patient has previously received Rystiggo at another facility, please provide last date received: _____

● If patient has previously received another therapy, please provide the name: _____ and the last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Seacoast: 843-366-2830 (Fax)

843-390-8200 (Phone)

Approved: