HERITAGE SPECIALTY PHARMACY

Rozanolixizumab-noli (Rystiggo) Patient Referral Form

Admissions Fax # 844-878-6917

Admissions Phone # 855-WE-R-RARE (855-937-7273)

Patient Demographics Information

Patient Name		SSN#	DOB
Patient Address			
Primary Phone	Cellular Phone	Work Phone	
Emergency Contact Name, Relationship		Emergency Contact Phone Number	

Additional Documentation Needed

- Copy of insurance cards
- Patient face sheet w/demographics
- History and Physical
- Antibody testing results
- CBC w/diff, BMP, & CMP
- Recent vitals including blood pressure

Patient Insurance Information

Insurance Plan #1			Insurance Plan #2		
Plan Address			Plan Address		
Plan Phone & Fax Numbers			Plan Phone & Fax Numbers		
Subscriber Name	DOB		Subscriber Name	DOB	
Policy Number	Group ID		Policy Number	Group ID	

Patient Clinical Information

Gender ☐M ☐F	Height (inches)	Weight (lbs.)	Allergies (food/drug)

Statement of Medical Necessity / Primary Diagnosis

ICD10: Description of diagnosis: Current MG-ADL Score:

Medication Information / Prescription and Orders

Medication: Rystiggo

Directions: Infuse SubQ with mechanical syringe pump at a rate of up to 20 mL/hr per manufacturer guidelines.

Quantity/Refills

Dispense:

6-week supply, refill x12mo. Unless otherwise noted

☐ Other

*If subsequent treatment cycles only

Start date of last cycle:

< 50 kg

☐ 420 mg (3 mL) SubQ every week for 6 weeks.

50-99 kg

☐ 560 mg (4 mL) SubQ every week for 6 weeks.

≥100 kg

☐ 840 mg (6 mL) SubQ every week for 6 weeks.

Premedications

☐ Give premedication(s) 30 minutes prior to infusion (*generics will be dispensed)*

Diphenhydramine	☐ 25-50 mg PO
Fexofenadine	☐ 180 mg PO
Acetaminophen	☐ 325-650 mg PO **OR** ☐ _____ mg PO

☐ Lidocaine 2.5% and prilocaine 2.5% (EMLA) topical cream: apply to SQ needle site prior to access PRN pain upon needle insertion.

☐ RN to instruct patient to hydrate pre/post infusion.

☐ Other

Quantity/Refills

Dispense:

Quantity #QS + PRN refills unless otherwise noted

☐ Other

Adverse Reaction Orders

In the event of an infusion reaction (i.e. fever, chills, backache, headache, rigors, etc.) the following order will be followed and the ordering provider will be notified:

- Mild reaction: Pause infusion and administer diphenhydramine 50 mg PO x1 dose. If needed, give an additional dose of diphenhydramine 50 mg PO x1 dose. Max 2 doses. Resume infusion once symptoms resolve.
- Moderate reaction: Stop infusion and administer diphenhydramine 50 mg PO x1 dose.
- Severe reaction (w/breathing problems): CALL 911, administer epinephrine 0.3 mg IM. #QS + PRN refills

Prescriber Information

Prescriber Name		Office Contact	
Practice Address		Practice Phone	
NPI#	License #	Practice Fax	
Physician Signature Required - Substitution Permitted	Date	Physician Signature Required - Dispense as Written	Date