ROZANOLIXIZUMAB-NOLI (RYSTIGGO®) PRESCRIBER ORDER FORM

Patient Name:		Date of Birth:		Gender:
Address:				
Phone:	Height:	☐ inches ☐ cm	Weight:	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

Allergies: ☐ NKDA or (List):

Prescription

RYSTIGGO® (rozanolixizumab-noli)

☐ **Less than 50kg:** Administer 420 mg (3mL) subcutaneously via syringe pump up to 20mL/hr once weekly for 6 weeks for 1 treatment cycle.

☐ **50kg to less than 100 kg:** Administer 560 mg (4mL) subcutaneously via syringe pump once weekly up to 20mL/hr for 6 weeks for 1 treatment cycle.

☐ **100kg and above:** Administer 840mg (6mL) subcutaneously via syringe pump once weekly up to 20mL/hr for 6 weeks for 1 treatment cycle.

Repeat cycle after ____ days from the first dose of the previous treatment cycle. Refill x1 year.
(Subsequent cycles to be administered no sooner than 63 days from start of previous treatment cycle.)

☐ Other: _____

Observe patient for 15 minutes after completion of infusion.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st *infusion* dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.

Pre-Medication Orders:

☐ _____

Lab Orders:

☐ _____

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary and that I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name:		Phone:	Fax:
Address:		NPI:	
City, State:	Zip:	Office Contact:	

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

Not valid for use for patients residing in Arizona, New York, and Wisconsin

