InfuCare Rx®

Rystiggo® Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940

✂ Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Home ☐ Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

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

☐ Clinical/Progress notes with supporting diagnosis
☐ H&P
☐ Positive serologic test for anti-AChR antibody for gMG
☐ Positive serologic test for anti-MuSK antibody for gMG
☐ MG-ADL Score: _____
☐ MGFA classification: _____
☐ Patient's demographics, including insurance information
☐ Please attach original prescription orders
☐ Current medications: _____
Previous therapies: ☐ eculizumab ☐ rituximab ☐ IVIG
☐ oral corticosteroids ☐ non-steroidal ISTs
☐ Previous live vaccine: _____ Date: _____

MEDICAL HISTORY

Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Delivery Method: ☐ Infusion Pump
Therapy Start Date: _____ Therapy End Date: _____
Nursing Coordination:
☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No
☐ Home health nursing coordination not necessary. Reason:
☐ MD office to administer to patient
☐ Home health nursing already coordinated

PRESCRIPTION INFORMATION

Rystiggo® (rozanolixizumab-noli) 280mg/2mL:

	Body Weight	Dose	Directions	Vials Dispensed
☐	Less than 50kg	420mg (3mL)	Administer SUBQ using infusion pump at a rate of up to 20mL/hr once weekly for 6 weeks. To be administered by a healthcare professional with 15 minutes post observation period.	12 vials
☐	50kg to less than 100kg	560mg (4mL)		12 vials
☐	100kg and above	840mg (6mL)		18 vials

Subsequent Dosing:

☐	Subsequent treatment cycles to be determined	no refills
☐	Subsequent treatment cycles to be every 63 days (9 weeks) from the start of the previous treatment cycle	8 refills

ORDERS/OTHER MEDICATIONS

- **Orders are initiated:**
- Infusion supplies as per protocol
- Anaphylaxis Kit orders as per protocol

ADDITIONAL COMMENTS:

Prescriber Signature: _____ **Date:** _____

✂

Revised 12 Mar 2024