Fax: 832-895-4040
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adaptIV infusion

Rystiggo (Rozanolixizumab-noli)

Provider Order Form rev. 11/27/2023

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV
☐ famotidine (Pepcid) 20mg PO
☐ methylprednisolone (Solu-Medrol) ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☐ **Rozanolixizumab-noli (Rystiggo)**
☐ Dose:
  ☐ Patient weight less than 50kg: 420mg
  ☐ Patient weight 50kg to less than 100kg: 560mg
  ☐ Patient weight 100kg and above: 840mg
☐ Frequency: once weekly for six weeks (one treatment cycle)
  ☐ Additional treatment cycles.
  _____ (Indicate number of cycles)
  - Treatment cycles will be given 63 days from the start of the previous treatment cycle.
☐ Monitor patients during administration and for 15 minutes after completion for clinical signs and symptoms of hypersensitivity reactions.
- Order expires one year from date signed

SPECIAL INSTRUCTIONS

* Administer subsequent treatment cycles based on clinical evaluation; the safety of initiating subsequent cycles sooner than 50 days from the start of the previous treatment cycle has not been established.

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____

Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK