INTRAMED Plus
infusion services

RYSTIGGO®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis: _____ Myasthenia gravis without (acute) exacerbation ICD-10 Code: G70.00
_____ Myasthenia gravis with (acute) exacerbation ICD-10 Code: G70.01
_____ Other: _____ ICD-10 Code: _____
Allergies: _____ (or attach list)

3. Clinical Information — Please fax with Infusion Order Form:

- Clinical Notes and Labs supporting primary diagnosis
- Recent Lab/Test Results including:
  - Anti-AChR+ serology and/or MuSK+ serology
- Medication List & Immunization Records
  - Documentation of previous gMG therapies trialed and outcomes (i.e. treatment failure, intolerance, contraindication, etc.)

Patient
Weight: _____ lbs.
Height _____ in.

Rystiggo (rozanolixizumab-noli)

J Code: J9333

4. Drug Order:

Patient weight	Dose	Directions
❑ Less than 50 kg	**420 mg**	Administer dose subcutaneously once weekly for 6 weeks (1 cycle)
❑ 50 kg to less than 100 kg	**560 mg**	
❑ 100 kg and above	**840 mg**	

Quantity/Refills
Doses Authorized: 6 (1 cycle) Number of cycles authorized (i.e. refills): _____ Repeat subsequent cycle(s) after _____ off-weeks. (Recommended: 3 weeks)

****Note: Shortest time observed between cycles was 3 week during clinical trials. ****

Pre-Medication Orders: _____

No Pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____

Dispense as written Substitution permitted

Printed Physician's Name with Credentials: _____ Phone #: _____

FAX ALL INFORMATION
CENTRAL FAX 803.999.1754

INFUSION CENTER LOCATIONS
BERKELEY CHARLESTON COLUMBIA GREENVILLE
CENTRAL INTAKE PHONE 803.999.1760