



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION

G70.0 Generalized Myasthenia Gravis (gMG) Other (ICD-10): _____ Diagnosis Description: _____

MG-ADL Score: _____ MGFA Classification: _____ AChR or MuSK antibodies: Yes No

MENINGITIS VACCINE: Patient HAS received first dose of both Conjugate (MenACWY) and Serogroup B (MenB) vaccines Yes No

RYSTIGGO® ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Strength	Directions	Refills
Rystiggo® (Rozanolixizumab-noli)	280mg/2ml Vial	<input type="checkbox"/> (Body Weight of Patient <50kg): Administer 420mg via subcutaneous infusion once weekly for 6 weeks. Administer for _____ cycles based on clinical evaluation > 63 days from the start of previous cycle. <input type="checkbox"/> (Body Weight of Patient ≥ 50kg to <100kg): Administer 560mg via subcutaneous infusion once weekly for 6 weeks. Administer for _____ cycles based on clinical evaluation > 63 days from the start of the previous cycle. <input type="checkbox"/> (Body Weight of Patient ≥ 100kg): Administer 840mg via subcutaneous infusion once weekly for 6 weeks. Administer for _____ cycles based on clinical evaluation > 63 days from the start of previous cycle.	<input type="checkbox"/> 1 Year <input type="checkbox"/> _____
Pre-Medication	Dose/Strength	Directions	
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed	
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg IV/PO <input type="checkbox"/> 50mg IV/PO	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed	
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed <input type="checkbox"/> Other: Inject 100mg IV 30 minutes prior to infusion	
<input type="checkbox"/>			

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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