TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

RYSTIGGO®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ Tax ID: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

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

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

Secondary Insurance (If Applicable): _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
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	☐ **(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. ☐ **(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. ☐ **(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.	☐ 1 Year ☐ _____

Pre-Medication	Dose/Strength	Directions
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Diphenhydramine	☐ 25mg IV/PO ☐ 50mg IV/PO	☐ Take 1 tablet PO prior to infusion or as directed OR ☐ Inject contents of 1 vial IV prior to infusion or as directed
☐ Methylprednisolone	☐ 40mg ☐100mg ☐ 125mg	☐ Inject contents of 1 vial IV prior to infusion or as directed ☐ Other: Inject 100mg IV 30 minutes prior to infusion
☐ _____	_____	_____

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.