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RYSTIGGO

(Rozanolixizumab)

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: _____ M: ☐ F: ☐ Address: _____
Phone: _____ City, State, Zip: _____
Email: _____

Allergies: _____

PRIMARY DIAGNOSIS

ICD-10 Code: _____

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

- | | |
|--|---|
| <input type="checkbox"/> Acetaminophen 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Ceterizine 10mg PO | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> Loratadine 10mg PO | <input type="checkbox"/> Other: _____ |

PRIMARY MEDICATION ORDER

Dosage

- ☐ Less than 50kg: 420mg
☐ 50kg to less than 100kg: 560mg
☐ 100kg and above: 840mg

Patient Weight: _____

Frequency

- ☐ Once weekly for six weeks (one treatment cycle)

lbs

kg

NOTES

ORDERING PROVIDER

Provider Name: _____	NPI: _____
Practice Name: _____	Phone: _____
Office Contact: _____	Fax: _____
Practice Address: _____	
City, State, Zip: _____	

Provider Signature: _____

Date: _____