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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: \_\_\_\_\_