vitalcare of SOUTH DALLAS

RYSTIGGO (ROZANOLIXIZUMAB-NOLI) ORDER SET

P: 945.212.3707 | **F:** 866.790.3580

☐ Home Infusion ☐ Alternate Site of Care

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 866.760.3580

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: ☐ Myasthenia Gravis w/out acute exacerbation (ICD-10 Code: G70.00)
☐ Myasthenia Gravis w/acute exacerbation (ICD-10: G70.01)
☐ Other: _____ (ICD-10: _____)

gMG Classification: ☐ II ☐ III ☐ IV

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Rystiggo

☐ Patients weighing less than 50kg (110 lbs.) Rystiggo 420mg subQ weekly for 6 weeks

☐ Patients weighing 50kg to <100kg (220 lbs.) Rystiggo 560mg subQ weekly for 6 weeks

☐ Patients weighing ≥100kg (220 lbs.) Rystiggo 840mg subQ weekly for 6 weeks

Cycle may be repeated based on clinical evaluation.

Refills: ☐ None ☐ Repeat for _____ cycle(s), subsequent cycle(s) to start ≥63 days from start of previous cycle

Other orders: _____

Lab Orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____

Required labs to be drawn by: ☐ Vital Care ☐ Referring Provider

Home biologic injection Ana-kit (adult):

- Dispense per protocol EpiPen 0.3mg IM (2-pack)

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Vital Care of South Dallas* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Vital Care selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____

VITALCARE.COM/LOCATIONS/VITAL-CARE-OF-SOUTH-DALLAS/

vitalcare® of SOUTH DALLAS

COMPREHENSIVE SUPPORT FOR RYSTIGGO THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's current medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., pyridostigmine, immunosuppressants, corticosteroids, or acetylcholinesterase inhibitors)? ☐ Yes ☐ No
    If yes, which drug(s)? _____
  - ☐ Has the patient required 2 or more courses of plasmapheresis/plasma exchanges and/or intravenous immune globulin for at least 12 months without symptom control? ☐ Yes ☐ No
  - ☐ Myasthenia Gravis Activities of Daily Living (MG-ADL) Score: _____
  - ☐ Does patient have a history of abnormal neuromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation? ☐ Yes ☐ No
  - ☐ Does the patient have a history of positive anticholinesterase test? ☐ Yes ☐ No
- ☐ Include labs and/or test results to support diagnosis
  - ☐ AChR antibodies or MuSK antibodies **(required)**
- ☐ If ordering a subsequent treatment cycle, and patient is new to Vital Care, please indicate the start date of the last completed cycle _____
- ☐ Other medical necessity: _____

Vital Care will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (866) 790-3580 or call (945) 212-3707 for assistance