Nevada Infusion
Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511
Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706
PH: 775-453-0667 | Fax: 775-470-8478

Rystiggo Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Myasthenia Gravis w/out acute exacerbation ICD-10: G70.00
- ☐ Myasthenia Gravis w/acute exacerbation ICD-10: G70.01
- ☐ Other:_____ICD-10:_____

ORDER FOR RYSTIGGO (rozanolixizumab-noli):

- ☐ Patients **weighing less than 50 kg** (110 lbs.) - **Rystiggo 420 mg/3 m**l subcutaneously once weekly for 6 weeks, next cycle to start 63 days from the start of previous cycle (6 weeks on therapy, 3 weeks off therapy) x 1 year.
- ☐ Patients **weighing 50 kg to <100 kg** (110- 220 lbs.) - **Rystiggo 560 mg/4 ml** subcutaneously once weekly for 6 weeks, next cycle to start 63 days from the start of previous cycle (6 weeks on therapy, 3 weeks off therapy) x 1 year.
- ☐ Patients **weighing more than >100 kg** (220 lbs.) - **Rystiggo 840 mg/6 ml** subcutaneously once weekly for 6 weeks, next cycle to start 63 days from the start of previous cycle (6 weeks on therapy, 3 weeks off therapy) x 1 year.
- ☐ Other Directions:_____

PRE-MEDICATIONS:

- ☐ Acetaminophen 650mg PO
- ☐ Diphenhydramine 25mg IV or PO or Zyrtec 10 mg PO
- ☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion
LABS ORDERS: _____ Fax results to: _____

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Revised 05/2026

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Supporting documentation to include past tried and/or failed therapies, intolerances, benefits or contraindications to conventional therapy. Please include tried and failed medications.

☐ Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., hydroxychloroquine, immunosuppressants, corticosteroids)?

☐ Yes OR ☐ No

If yes, which drug(s)? _____

☐ Has the patient tried and failed Benlysta Therapy?

☐ Yes OR ☐ No

☐ Myasthenia Gravis Activities of Daily Living (MG-ADL) Score: _____

☐ Include labs and/or test results to support diagnosis

☐ Other medical necessity: _____

Additional REQUIRED Information:

☐ ANA, Anti-dsDNA, Anti-Ro/SSA and/or anti-Smith antibodies (please attach lab results)

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