PARAGON HEALTHCARE

A Carelon Company

RYSTIGGO (ROZANOLIXIZUMAB) INFUSION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:		ZIP:
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:			Email:
Address:		City:	State: ZIP:
NPI #:	DEA#:		Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Frequency	Refills
Rystiggo (rozanolixizumab)	☐ 420mg subQ ☐ 560mg subQ ☐ 840mg subQ ☐ Other: _____	☐ Weekly for 6 weeks ☐ Other: _____	☐ None ☐ Repeat for _____ cycle(s), subsequent cycle(s) to start ≥63 days from start of previous cycle ☐ _____

Other orders: _____

Lab Orders: _____ Lab frequency: _____

Required labs to be drawn by: ☐ Paragon ☐ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* 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.

Prescriber Signature: X **Date:**

PARAGON HEALTHCARE

A Carelon Company

COMPREHENSIVE SUPPORT FOR RYSTIGGO (ROZANOLIXIZUMAB) THERAPY

PATIENT INFORMATION

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: _____
- ☐ gMG Classification: ☐ II ☐ III ☐ IV
- ☐ 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 Paragon, please indicate the start date of the last completed cycle _____

☐ Other medical necessity: _____