Ascension Rx

Rozanolixizumab-noli (Rystiggo & Biosimilar) Injection Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☐ Baseline
    - ☐ CBC with Differential
    - ☐ CMP
  - ☐ Maintenance (every _____)
    - ☐ CBC with Differential
    - ☐ CMP
- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____ ☐

Nursing Order

- ☑ Do not administer with an active infection, including clinically important localized infection, or if patient is taking antibiotics for current infection.
- ☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

Pre-Medications (Not routinely recommended, use only if clinically indicated)

- ☐ Acetaminophen 650 mg PO once
- ☐ Diphenhydramine 25 mg PO once
- ☐ Diphenhydramine 25 mg IV once
- ☐ Diphenhydramine 50 mg PO once
- ☐ Diphenhydramine 50 mg IV once
- ☐ Famotidine 20 mg IV once
- ☐ Famotidine 20 mg PO once
- ☐ Dexamethasone 20 mg IV once
- ☐ Dexamethasone 20 mg PO once
- ☐ Methylprednisolone 125 mg IV once
- ☐ Methylprednisolone 40 mg IV once
- ☐ Other: _____

Ascension Rx

Rozanolixizumab-noli (Rystiggo & Biosimilar) Injection Order Form

Medication Orders (select only one)

Initial Treatment Cycle:

For patients < 50 kg

☐ Rozanolixizumab 420 mg SQ over 15 minutes once weekly for 6 weeks, followed by 420 mg SQ once weekly for 6 weeks after _____ days from the 1st dose of the previous treatment cycle.

For patients 50 kg to < 100 kg

☐ Rozanolixizumab 560 mg SQ over 15 minutes once weekly for 6 weeks, followed by 560 mg SQ once weekly for 6 weeks after _____ days from the 1st dose of the previous treatment cycle.

For patients ≥ 100 kg

☐ Rozanolixizumab 840 mg SQ over 15 minutes once weekly for 6 weeks, followed by 840 mg SQ once weekly for 6 weeks after _____ days from the 1st dose of the previous treatment cycle.

Refills:
(Refills for one year from date of signature unless indicated)

☐ Zero ☐ For 12 months ☐ _____

To be completed by Infusion Center staff only:

Biosimilar substitution/Product Dispensed: _____ J-Code: _____
Rounded Dose: _____ mg

Rationale for Substitution:

☐ Payer-mandated substitution
☐ Financial stewardship
☐ Patient access / hardship

Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

Administer via subcutaneous infusion via a subcutaneous infusion pump over 15 minutes. Administer using an infusion set with a 26 gauge or larger needle and tubing equal to or less than 61 centimeters in length.

DO NOT flush the infusion line after infusion completes.

Follow device manufacturers' instructions for administration.

Monitor patients for 15 minutes after each subcutaneous infusion.

Emergency / Hypersensitivity Orders

☑ Notify provider for next steps once patient stabilized
☑ Follow standard orders for management of allergies and anaphylaxis reactions
☑ In absence of standard protocol, follow the orders below:
  ☑ Nursing to stop infusion, maintain airway, place supine, elevate legs, O_2 2 L NC
  ☑ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)

Ascension Rx

Rozanolixizumab-noli (Rystiggo & Biosimilar) Injection Order Form

- ☑ Diphenhydramine 25 mg IV q6h PRN itching/hives
- ☑ Hydrocortisone 100 mg IV Once PRN hypersensitivity
- ☑ Methylprednisolone 125 mg IV Once PRN hypersensitivity
- ☑ Famotidine 20 mg IV Once PRN hives/itching
- ☑ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
- ☑ Normal Saline 1000 mL IV bolus Once PRN hypotension

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated