Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Rozanolixizumab-noli (RYSTIGGO) Infusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Treatment Start Date: _____ Allergies: _____

Weight: _____kg Height: _____cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

1. **FACE SHEET with complete INSURANCE information and patient CONTACT information**
2. **Recent VISIT NOTE to support treatment (if not available in Epic)**
3. **LAB RESULTS for any required prescreening (if not available in Epic)**
4. **DIAGNOSIS CODE _____**
5. **Patient NAME and DATE OF BIRTH on EVERY page faxed**

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.
2. Rozanolixizumab is indicated for adult patients with generalized myasthenia gravis that is anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (muSK) antibody positive.
3. Aseptic meningitis has been reported in patients treated with rozanolixizumab. Rozanolixizumab may increase risk of infection.
4. Hypersensitivity reactions have occurred following administration, typically within 1 day to 2 weeks of administration.
5. Patient should be up to date with all immunizations before initiating therapy. Avoid use of live or live-attenuated vaccines in patients during treatment.
6. Alternative agents should be considered for treatment of myasthenia gravis during pregnancy.
7. Select dose based on patient's actual body weight.
    a. Weight less than 50 kg: 420 mg
    b. Weight between 51 and 99 kg: 560 mg
    c. Weight greater than or equal to 100 kg: 840 mg

NURSING ORDERS:

1. TREATMENT PARAMETER - Hold treatment and notify provider if patient has signs or symptoms of infection
2. Monitor for signs or symptoms of hypersensitivity reaction during and for 15 minutes after infusion.
3. Allow vials to reach room temperature for ~30 minutes prior to use.
4. Administer only via SUBQ infusion using an infusion pump. Administer using an infusion set with a 26 gauge or larger needle and tubing ≤61 cm in length. Following completion of infusion, do not flush infusion line, as infusion volume takes into account volume losses in line. Discard remaining solution.

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MEDICATIONS:

- PROVIDER TO PHARMACIST COMMUNICATION - Administered once weekly x6 doses with subsequent cycles starting no sooner than 63 days from start of previous cycle (day 1, 8, 15, 22, 29, and 36 every 63 days).
- Rozanolixizumab-noli (RYSTIGGO) subcutaneous infusion, ONCE, Every Visit,
  Infuse via syringe pump. Do not shake. Do not infuse where the skin is tender, bruised, red, or hard. Avoid infusing into tattoos, scars, or stretch marks. Rotate infusion sites for subsequent administrations. Monitor for 15 minutes after completion for signs and symptoms of hypersensitivity reactions.

Dose: (Select One)

☐ 420 mg (weight < 50 kg)
☐ 560 mg (weight 50-100 kg)
☐ 840 mg (weight ≥ 100 kg)

Interval: Every visit on Day 1, 8, 15, 22, 29 and 36 every 63 days (6 weekly doses followed by 6 weeks off).

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – if hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. Diphenhydramine (BENADRYL) injection, 25–50 mg, intravenous, AS NEEDED X 1 dose for hypersensitivity reaction.
3. EPINEPHrine HCl (ADRENALIN) injection, 0.5 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity reaction.
4. Hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction. Dilute vial by either pressing chamber for Act-O-Vial or diluting powder vial with 2 mL SWFI or NS for injection.
5. Famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose, for hypersensitivity reaction.

STAFF DIRECTIVES (as applicable):

1. Infusion staff to follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. Pharmacist to select appropriate admixture options including (as applicable) formulation, fluid base type, volume, concentration, administer-over time, and rate according to the package insert, drug information references, and facility policies, procedures, and practice standards.
3. Biosimilar substitutions may be permitted by infusion site policies or Collaborative Drug Therapy Management (CDTM) agreements. A pharmacist may substitute the biosimilar for authorized reasons, which may include infusion site preference or insurance reimbursement requirement. If it is NOT acceptable to substitute per site preference or insurance, check to Dispense as Written (DAW) ☐ and note the REQUIRED biosimilar: _____
4. Pharmacist may select or update orders to the site's preferred biosimilar. In addition, if insurance requires a specific biosimilar agent for reimbursement, pharmacy may update the order at sites with a Collaborative Drug Therapy Management agreement (CDTM). If it is NOT acceptable to substitute per site preference or insurance, check to Dispense as Written (DAW) ☐ and note the REQUIRED biosimilar: _____

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By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ **License #:** _____ **Date:** _____

Print Name: _____ **Phone:** _____ **Fax**:_____

Plan will expire 1 year after signature date at which time a new order will need to be placed

Contact the Referral Team directly for assistance at the centralized numbers below (do not contact individual clinics) **INFUSION REFERRAL TEAM** **Fax completed orders to (503) 346-8058** Phone (providers only) (971) 262-9645	☑ **Please indicate the patient's preferred clinic location below**	
	☐ **BEAVERTON** OHSU Knight Cancer Institute	15700 SW Greystone Court Beaverton OR 97006
	☐ **NW PORTLAND** Legacy Good Samaritan campus	Medical Office Building 3 – Suite 150 1130 NW 22nd Ave, Portland OR 97210
	☐ **GRESHAM** Legacy Mount Hood campus	Medical Office Building 3 – Suite 140 24988 SE Stark, Gresham OR 97030
	☐ **TUALATIN** Legacy Meridian Park campus	Medical Office Building 2 – Suite 140 19260 SW 65th Ave, Tualatin OR 97062
	☐ **Non-Legacy community providers only** **EAST PORTLAND** Adventist Health Portland campus	Pavilion – 10000 SE Main St – Suite 350 Portland, Oregon 97216
Infusion orders located at: www.ohsuknight.com/infusionorders	Referral team will consider other locations as appropriate if selected site is not available, if treatment is urgent, or for patient preference.	