

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:

Patient Demographics, Most Recent Office Visit Note, Insurance Information, AChR Antibody Positive Test

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): G70.00 G61.81 G70.001D Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- Center will use Hypersensitivity protocol established by Infusion for Health and PI
- Tried & Failed Medications:
 - IVIG / Ultomiris
 - Other: _____
- AChR Antibody Positive Test (Attach results)

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

Other: _____
 Dose: _____ Route: _____ Frequency: _____

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- Other _____ every _____
- Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

- Vyvgart Hytrulo Subcutaneous Dosing
 - For gMG:
 - Dose: 1,008mg/11,200 units administered subcutaneously over approximately 30-90 seconds
 - Frequency: Once weekly for 4 weeks (one treatment cycle)
 - Additional Treatment Cycles: _____
 - *Subsequent cycles may require additional insurance authorization.
 - *Treatment cycles will be given 50 days from the start of the previous treatment cycle. (Order will expire one year from date signed.)
 - For CIDP:
 - Dose: 1,008mg/11,200 units administered subcutaneously over approximately 30-90 seconds
 - Frequency: Once weekly
 - Monitor patients for 30 minutes after the completion of this injection

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS:

 Provider Name (Print) Provider Signature Date

Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.