Vyvgart

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 ☐ G70.01 ICD 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 Intravenous Dose

☐ Dose: 10mg/kg in 0.9% Sodium Chloride

Total Dose: _____ (Max dosage 1200mg)

Route: ☑ IV

Frequency: Once weekly for 4 weeks,

*If new start, prescriber to evaluate frequency after initial treatment. Will need a new order.

☐ 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.)

☐ Monitor patient for one hour after completion of infusion

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.***