

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Recent IGG Level (If available)
- Medication List • EMG Confirming MG • MG-ADL Assessment • Tried and Failed Therapies (including duration)

PRIMARY DIAGNOSIS

- G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
- G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
- Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: No recommended standard pre-meds for Vyvgart.
- Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- Vyvgart 10mg/kg (_____mg, not to exceed 1200mg) IV once weekly x4 doses
 ***Provider to determine frequency of cycles. Check **ONE**:
 One cycle only. (Provider to submit new referral when due for following cycle.)
 Repeat cycle every 28 days from last dose for 6 total cycles for one full year
 Repeat cycle every _____ days from last dose
 Other _____

***Regardless of frequency, authorization will be obtained for 6 cycles (1 full year)

***If a treatment is delayed by more than 3 days, then the cycle is restarted

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature _____

Date _____