Chicago Illinois
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REJUVEINATE

ORDER FORM VYVGART:®

Date: ____________________

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION		
Physician Name*:		Practice Name:
Address:		Office Contact*:
Phone:	Fax:	Email (for updates):

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

VYVGART*:

____ Dosing: 10 mg/kg IV weekly x 4 weeks

☐ Other:_______________

☐ Total doses: ☐1yr ☐Other:___________ ☐Refill:___________________

Physician Signature ______________________________

Date (Order is Valid for One Year)______________________

Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

_____ Myasthenia Gravis (gMg)

_____ Other__________________________

Last Infusion/Injection Date: ________________________

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

_____ Positive AchR

_____Other

STANDING LAB ORDERS: _____ CMP _____ CBC Frequency ________________________________

NOTES/ADDITIONAL COMMENTS: ☐ **Other**______________

ORDERING PROVIDER

Signature **X** ______________________________ Date ______________

Provider ________________________ Phone ____________ Fax ____________