

TN  
100 Covey Drive  
Suite 307  
Franklin, TN 37067



Office: 212-803-3339 Fax : 646-768-8600

# ORDER FORM VYVGART: °

Date: \_\_\_\_\_

| PATIENT INFORMATION |                   |                                                            |
|---------------------|-------------------|------------------------------------------------------------|
| Name:               | DOB:              | SEX: M <input type="checkbox"/> F <input type="checkbox"/> |
| Allergies:          | Date of Referral: |                                                            |

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

| REFERRAL STATUS                                                                                                                                                                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> 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:                                                                                    | REQUIRED DOCUMENTATION CHECKLIST:                                                                                                                                                                                     |
|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>____ Myasthenia Gravis (gMg)</p> <p>____ Other _____</p> <p>Last Infusion/Injection Date: _____</p> | <p>____ Patient Demographics</p> <p>____ Insurance Card/Information</p> <p>____ Clinical/Progress Notes supporting DX</p> <p>____ Current Medication List and H&amp;P</p> <p>____ Positive AchR</p> <p>____ Other</p> |

STANDING LAB ORDERS: \_\_\_\_ CMP \_\_\_\_ CBC Frequency \_\_\_\_\_

NOTES/ADDITIONAL COMMENTS: ☐ Other \_\_\_\_\_

## ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_