☐ **Borough Park**
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ **Crown Heights**
555 Lefferts Avenue
Brooklyn, NY 11225

☐ **Manhattan**
57W 57Street
Suite 601
New York, NY 10019

☐ **Manhasset**
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ **Rockville Centre**
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ **Elmsford/ Terrytown**
555 Taxter Road
3rd Floor
Elmsford, NY 10523

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

☐ **Manhattan**
225 E 70th Street
Suite 1E
New York, NY 10021

☐ **Queens**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ **Manhattan**
225 East 70th Street
New York, NY 10021

☐ **Holbrook/ Ronkonkoma**
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ **Scarsdale**
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ **5 Towns**
141 Washington Avenue
Cedarhurst, NY 11559

☐ **Long Beach**
917 Beech Street
Long Beach, NY 11561

☐ **Riverhead**
1228 E Main Street
Suite A
Riverhead, NY 11901

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 ____________