

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies See List NKDA City, State, Zip: _____

Weight: _____ kg lbs Height: _____ in cm Email: _____

PRIMARY DIAGNOSIS

Chronic inflammatory demyelinating polyneuropathy (G61.81)

Myasthenia gravis without (acute) exacerbation (gMG) (G70.00)

Myasthenia gravis with (acute) exacerbation (gMG) (G70.01)

Other: _____

PRESCRIPTION

Myasthenia Gravis

Vyvgart Hytrulo 1,008mg/11,200 units subcutaneous injection once weekly x 4 doses

Please indicate frequency of cycle. Choose **ONE**:

One cycle only. (New referral to be sent for any future doses)

Repeat cycles every 28 days from last dose for _____ total cycles

Other: _____

CIDP

Vyvgart Hytrulo 1,008mg/11,200units SubQ injection once weekly

Other: _____

Has patient received any doses of this medication in the past? Yes No

Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- Insurance card
- Patient demographics
- Most recent labs
- EMG confirming MG
- H&P
- Medication list
- Tried and failed therapies (including duration)
- MG-ADL assessment

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol (*See aiscaregroup.com for detailed policy*)

Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

Per infusion center protocol: No recommended standard pre-meds for Vyvgart Hytrulo

Provider Prescribed: _____

LAB ORDERS—PLEASE INCLUDE FREQUENCY

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

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.