

Date Required: \_\_\_\_\_ Ship To:  Home  Office  Other: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Alternate Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_

**INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)**

Primary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
 Prescription Card: \_\_\_\_\_ ID: \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_

**To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:**

**DIAGNOSIS**

G70.00 Generalized Myasthenia Gravis (gMG)  
 G70.01 Myasthenia Gravis with Exacerbation

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Clinical/Progress notes with supporting diagnosis  
 H&P  
 Patient's demographics, including insurance information  
 Please attach original prescription orders  
 Current medications: \_\_\_\_\_  
 Previous therapies:  eculizumab  rituximab  IVIG  
 oral corticosteroids  nonsteroidal ISTs  
 Previous live vaccine: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL HISTORY**

Patient Weight: \_\_\_\_\_  kg  lbs Height: \_\_\_\_\_  cm  in  
 Allergies: \_\_\_\_\_  
 Line Access:  Peripheral  PICC  Port  
 Delivery Method:  Infusion Pump  Other: \_\_\_\_\_  
 Therapy Start Date: \_\_\_\_\_ Therapy End Date: \_\_\_\_\_  
 Nursing Coordination:  
 Pharmacy to coordinate home health nursing visit as necessary:  Yes  No  
 Home health nursing coordination not necessary. Reason:  
 MD office to administer to patient  
 Home health nursing already coordinated

**PRESCRIPTION INFORMATION**

**Vyvgart Prescription:**

10mg/kg body weight weekly for 4 doses. (Once weekly x 4 weeks.) Maximum dose: 1.2gm. Subsequent treatment cycles may be administered based on clinical evaluation and no sooner than 50 days from the start of the previous treatment cycle.

**PREMEDICATION ORDERS/OTHER MEDICATIONS**

**Flush Protocol**

NaCl 0.9% 5mL  Heparin 10 units per mL  
 NaCl 0.9% 10mL  Heparin 100 units per mL  Other: \_\_\_\_\_

**Premedications & Other Medications**

Infusion supplies as per protocol  Acetaminophen \_\_\_\_\_ mg PO prior to infusion  
 Anaphylaxis Kit orders as per protocol  Diphenhydramine \_\_\_\_\_ mg PO

**ADDITIONAL COMMENTS:**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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