InfuCare Rx

Vyvgart™ Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940

✂ Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Home ☐ Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

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)

☐ Clinical/Progress notes with supporting diagnosis
☐ H&P
☐ Patient's demographics, including insurance infomation
☐ 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
☐ NaCl 0.9% 10mL
☐ Heparin 10 units per mL
☐ Heparin 100 units per mL
☐ Other: _____

Premedications & Other Medications

☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol
☐ Acetaminophen _____ mg PO prior to infusion
☐ Diphenhydramine _____ mg PO

ADDITIONAL COMMENTS:

Prescriber Signature: _____ **Date:** _____

✂