

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

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Date of Birth: _____ Gender: _____	DEA #: _____ NPI #: _____
Emergency Contact: _____ Phone: _____	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: _____	BIN: _____	PCN: _____

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

DIAGNOSIS	MEDICAL HISTORY
☐ G70.00 Myasthenia Gravis without (acute) exacerbation ☐ G70.01 Myasthenia Gravis with (acute) exacerbation ☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in Allergies: _____ Line Access: ☐ Peripheral ☐ PICC ☐ Port Therapy Start Date: _____ Therapy End Date: _____
☐ Patient's demographics, including insurance information ☐ Clinical/Progress notes with supporting diagnosis ☐ H&P MG Indication: ☐ Anti-AChR Antibody Positive ☐ Anti-MuSK Antibody Positive ☐ Triple seronegative ☐ Anti-LRP4 Antibody Positive ☐ MG-ADL Score: _____ ☐ MGFA classification: _____ CIDP Indication: ☐ Biopsy Results ☐ Electromyography (EMG) Results ☐ CSF Studies ☐ INCAT ☐ I-RODS ☐ mRS ☐ Original Prescription Orders Attached Previous therapies: ☐ eculizumab ☐ rituximab ☐ IVIG ☐ oral corticosteroids ☐ non-steroidal ISTs	☐ Current medications: _____ ☐ Previous live vaccine: _____ 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

Indication:	Drug/Strength:	Directions:	Quantity:	Refills:
☐ gMG	☐ Vyvgart® Vial 400mg/20mL IV: 10mg/kg (max 1.2gm) IV over one hour ☐ Vyvgart Hytrulo® Vial 1,008mg/11,200 units (5.6mL) SUBQ over 30-90 seconds ☐ Vyvgart Hytrulo® PFS 1,000mg/10,000 units (5mL) SUBQ over 20-30 seconds	Administer once weekly for 4 weeks (4 once-weekly treatments = 1 treatment cycle) with _____ days between treatment cycles (after last dose)	4 doses = 1 cycle	____ or ☐ 1 year.
☐ CIDP	☐ Vyvgart Hytrulo® Vial 1,008 mg/11,200 units (5.6mL) SUBQ over 30-90 seconds ☐ Vyvgart Hytrulo® PFS 1,000 mg/10,000 units (5mL) SUBQ over 20-30 seconds	Once weekly	4 doses = 1 cycle	____ or ☐ 1 year.

ORDERS/OTHER MEDICATIONS

Orders are initiated: ☐ Infusion supplies as per protocol ☐ Anaphylaxis Kit orders as per protocol	Flush Protocol (For Vyvgart® intravenous infusion only) ☐ NaCl 0.9% 10mL ☐ Before and after infusion ☐ Other: _____
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ADDITIONAL COMMENTS:

Prescriber Signature: _____ **Date:** _____

