Vyvgart Infusion Order

LivWell INFUSIONS

Fax 888 511-7654 *Phone 888 864-7341*

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

◯ G70.00 Myasthenia Gravis without Exacerbations

◯ G70.01 Myasthenia Gravis with Acute Exacerbation

◯ Other _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ICD-10 _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

VYVGART ORDER

Vyvgart Dose: 400mg/20mL vial in a 20mL single dose vial

◯ Infuse _____mg/kg OR _____ mg intravenously over one hour

◯ Initial treatment cycle: 1 time weekly for 4 weeks: 3 cycles

- ◯ 4 cycles
- ◯ 5 cycles
- ◯ 6 cycles

Date of last Vyvgart Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____