*Los Angeles, CA*
2080 Century Park East
Suite 710
Los Angeles, CA 90067

ThrIVewell INFUSION WEST
Office: 310-481-9944 Fax : 310-766-7001

MMI

# ORDER FORM VYVGART®

Date: _____

## PATIENT INFORMATION

| | | |
|---|---|---|
| Name: | DOB: | SEX: M ☐ F ☐ |
| Allergies: | Date of Referral: | |

## PHYSICIAN INFORMATION

| | |
|---|---|
| Physician Name*: | Practice Name: |
| Address: | Office Contact*: |
| Phone: Fax: | Email (for updates): |

## REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

## VYVGART*:

____ Dosing: 10 mg/kg IV weekly x 4 weeks
☐ Other:_____
☐ Total doses: ☐1yr ☐Other:_____ ☐Refill:_____

**Physician Signature** _____ **Date (Order is Valid for One Year)**_____

*Infusion will be administered per MPP policy and protocols*

## REQUIRED DIAGNOSIS:

_____ Myasthenia Gravis (gMg)

_____ Other_____

**Last Infusion/Injection Date:** _____

## REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

_____ Positive AchR

_____Other

STANDING LAB ORDERS: _____ CMP _____ CBC Frequency _____

**NOTES/ADDITIONAL COMMENTS:** ☐**Other**_____

## ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____