Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

ThrIVewell™ INFUSION

Mission Medical

Office: 212-803-3339 Fax : 646-768-8600

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 _____