

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



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:	REQUIRED DOCUMENTATION CHECKLIST:
____ Myasthenia Gravis (gMg) ____ Other _____	____ Patient Demographics ____ Insurance Card/Information ____ Clinical/Progress Notes supporting DX ____ Current Medication List and H&P ____ Positive AchR ____ Other _____
Last Infusion/Injection Date: _____	

STANDING LAB ORDERS: ____ CMP ____ CBC Frequency _____

NOTES/ADDITIONAL COMMENTS: ☐ Other _____

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____