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 _____

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 _____