RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

Vyvgart Referral Order Form

Patient Information

Patient Name:	Patient DOB:
Patient Phone #:	Sex of Patient:

Provider Information

Ordering Provider Name:	NPI # of Prescribing Provider:
Office Contact Name:	Office Phone #:
Office Contact Fax #:	Office Contact Email:

Vyvgart Medication Orders

Dosage

- _____ 10mg/kg IV (Max dose = 1.2G) once weekly for 4 weeks. Subsequent treatment cycles may be administered based on clinical evaluation and no sooner than 50 days from the start of the previous treatment cycle
- _____ Other _____

Patient Weight: _____ Lbs or _____ Kg

Diagnosis with ICD 10 code **(REQUIRED)**

- Diagnosis: _____ Myasthenia Gravis _____Other _____
- ICD 10 code _____

Pre-Medication	Refills
● Tylenol _____mg ● Benadryl _____ mg __IV or ___PO	● Zero _____ ● Treatments for 1 year _____
● Solumedrol IV Push _____ mg ● Other _____	● Other _____

Required Documentation

○ **Insurance Cards (Front and Back)**	○ **Patient Demographics** ○ **Lab Results – CMP, CBC**	○ **Recent Progress Notes**

Special Instructions/Notes

_____ _____

Prescribing Provider Signature **Date of Signature**