



MOUNTAIN GRACE
HOME INFUSION

+1 833-360-1212 info@mginfusion.com

+1 (760) 400-6905

VYVGART

Date of order: _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Update Order ☐ Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____
ICD-10 code (required): ☐ G70.00 ☐ G70.01 ICD Description: _____
Allergies: _____ Weight (lbs/kg): _____ Height: _____
Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: info@managecaresolutions.com
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- ☒ Provide patient care in accordance with Mountain Grace Home Infusion clinical protocols and the medication's Prescribing Information (PI), including the recognition and management of hypersensitivity reactions.

THERAPY ADMINISTRATION

- ☒ Vyvgart Intravenous Infusion
Dose: 10mg/kg (max dosage 1200mg)
Frequency: Once weekly for 4 weeks (one treatment cycle)
Additional Treatment Cycles: _____
Subsequent treatment cycles may require additional insurance authorization. Each treatment cycle may be administered up to 50 days from the start date of the previous cycle, unless otherwise specified in the Special Instructions. This order expires one (1) year from the date it is signed.
To receive the brand-name medication, the prescribing provider must clearly write "Brand Medically Necessary" on the prescription. If this notation is absent, I4H may dispense an FDA-approved generic equivalent or biosimilar, when available.

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ Other _____ ☐ Frequency _____

☐ Please check this box if you DO NOT authorize Mountain Grace Home Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

Pre-meds not usually indicated

- ☐ Diphenhydramine ☐ 25mg / ☐ 50 mg ☐ PO / ☐ IV
☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650 mg PO
☐ Other: _____
Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

Provider Name (Print) : _____

Provider Signature : _____

Date : _____

Please send it to this email: info@mginfusion.com