TwelveStone Health Partners

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Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

Twelv	eStone	
HEALTH	PARTNERS	

VYVGART ORDER FORM						
Date: ICD-10 Code:						
Patient Name: Allergies:				☐ New Start		
Date of Birth:Ibs OR		Weight:Ibs OR	kg	Continuing Therapy: Last Dose:		
		PROVIDER	INFORMATION			
Ordering Provider:		_ Provider Fax:				
Provider NPI: P			– Provider Address:			
Provider Phone:						
MEDICATION ORDER						
Vyvgart	 Vyvgart 10mg/kg IV once weekly x four weeks (one treatment cycle). Subsequent treatment cycles may be ordered based on clinical evaluation. I authorize additional cycles of treatment. Each subseq cycle will be scheduled 50 days from the start of the previous treatm cycle, unless otherwise specified. The ordering of subsequent cycle treatment should be based on clinical evaluation. Max dose of 1200mg infusion. 		quent ment	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: ✓ Positive AChR antibody test		
PRE-MEDICATIONS						
Oral Acetaminophen:325mg500mg650mg Loratadine: 10mg Cetirizine: 10mg Diphenhydramine:25mg50mg Famotidine:20mg40mg Ibuprofen:200mg400mg600mg Ondansetron:4mg8mg Other:		 Diphenhy Famotidin Methylpre Hydrocort 	 Dexamethasone:4mg8mg Diphenhydramine:25mg50mg Famotidine:20mg40mg Methylprednisolone: 125mg Hydrocortisone: 100mg Ondansetron:4mg8mg 			
LAB ORDER	RS (please indicate any labs t	o be drawn and frequency)			
Surveillance lab ordering and monitoring is the responsibility of the prescriber By signing below, I certify that the above therapy is medicall Dispense as Written:		to 800-223-406 • History & Phy • Patient Demo • Medication Li • Recent Lab V • MGADL Score cally necessary.	 (Please fax this signed order form, along with the following documents to 800-223-4063) History & Physical, Last Office Visit Note Patient Demographics and Insurance Information Medication List Recent Lab Work MGADL Score and MGFA Classification Iy necessary. Prescriber's Signature (SIGN BELOW) Substitution Allowed:			
Prescriber Name)	Date	_ Prescriber Nam	e	Date	
	information contained in this foodimile may be	a confidential and is intended calely for	the way of the normed regimes			

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