TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: referral@12stonehealth.com

VYVGART ORDER FORM

Patient Name: _____ ICD-10 Code: _____

Date of Birth: _____ Allergies: _____

Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ 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 subsequent cycle will be scheduled _____ days from the LAST dose of the previous treatment cycle. The ordering of subsequent cycles of treatment should be based on clinical evaluation.

✓ Max dose of 1200mg infusion.

PRE-MEDICATIONS

Oral

- ☐ Acetaminophen: ____325mg ____500mg ____650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: ____25mg ____50mg
- ☐ Famotidine: ____20mg ____40mg
- ☐ Ibuprofen: ____200mg ____400mg ____600mg
- ☐ Ondansetron: ____4mg ____8mg
- ☐ Other: _____

IV

- ☐ Dexamethasone: ____4mg ____8mg
- ☐ Diphenhydramine: ____25mg ____50mg
- ☐ Famotidine: ____20mg ____40mg
- ☐ Methylprednisolone: 125mg
- ☐ Hydrocortisone: 100mg
- ☐ Ondansetron: ____4mg ____8mg
- ☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 615-278-3355)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work
- MGADL Score and MGFA Classification

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature *(SIGN BELOW)*

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

_____ _____

Prescriber Signature Date

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