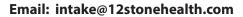
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





	VYVGART HY	YTRULO ORDER	FORM		
Date:	ICD-10 Code:	ICD-10 Code:			
Patient Name:	Allergies:		New Start		
Date of Birth:	Weight:Ibs	OR kg	☐ Continuing Th	nerapy: ast Dose:	
PROVIDER INFORMATION					
Ordering Provider: Provider Fax:					
Provider NPI:		Provider Addres	Provider Address:		
Provider Phone:					
	MED	ICATION ORDER			
□ gMG: Infuse Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) 1,008mg/11,200 units subcutaneously over 30 to 90 seconds once weekly x four weeks (one treatment cycle). Subsequent treatment cycles may be ordered based on clinical evaluation. gMG: I authorize additional cycles of treatment. Each subsequent cycle will be scheduled 50 days from the start of the previous treatment cycle, unless otherwise specified. The ordering of subsequent cycles of treatment should be based on clinical evaluation. □ CIDP: Infuse Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) 1,008mg/11,200 units subcutaneously over 30 to 90 seconds weekly. Refills (CIPD):					
PRE-MEDICATIONS					
Oral □ Acetaminophen:325mg500mg650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Ibuprofen:200mg400mg600mg □ Ondansetron:4mg8mg □ Other:		☐ Diphent☐ Famotic☐ Methylp☐ Hydrocc☐ Ondans	□ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg		
LAB ORDERS (p	uency) O	OTHER REQUIRED DOCUMENTATION			
Surveillance lab ordering and monitoring is the responsibility of the prescriber By signing below, I certify that the above therapy is med		800-223-4063 • History & Pr • Patient Dem • Medication I • Recent Lab • MGADL Sco	(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 ically 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.					
Dispense as Written:	Substitution A	Allowed:			
Prescriber Signature	 Date	Prescriber S	ignature	 Date	