

VYVGART™ (efgartigimod alfa-fcab)
Order/Referral Form



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 Greenfield, WI 53228
 Phone: (414) 460-3195
 Fax: (414) 763-0063
 www.gtinfusions.com

Patient Information		
Patient Name:	Patient DOB:	
Referral Status		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Restart	<input type="checkbox"/> Medication/Order Change
<input type="checkbox"/> D/C		
Diagnosis and ICD 10 Code		
<input type="checkbox"/> Generalized Myasthenia Gravis (gMG)	ICD 10 Code: G70.00	
<input type="checkbox"/> Myasthenia Gravis with Exacerbation	ICD 10 Code: G70.01	
<input type="checkbox"/> Other Diagnosis:	ICD 10 Code:	
Required Documentation		
<input type="checkbox"/> Patient demographics	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis	
<input type="checkbox"/> Copy of patient insurance card(s) – front & back	<input type="checkbox"/> Labs and tests	
<input type="checkbox"/> Tried and Failed therapies	<input type="checkbox"/> Current Medication and Allergy List	
Medication Orders		
<input type="checkbox"/> Initial Dose: VYVGART™ – 10mg/kg body weight once weekly for 4 doses. Maximum dose: 1.2gm		
<input type="checkbox"/> Maintenance Dose: VYVGART™ – 10mg/kg body weight once weekly for 4 doses. Subsequent treatment cycles may be administered based on clinical evaluation, no sooner than 50 days from the start of the previous treatment cycle.		
Notes (Additional Info)		
Premedication, adverse and anaphylactic reactions and post infusion will be treated per Gamma Therapeutic Center protocol.		
Prescriber Information		
Prescriber Name:	NPI #:	
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:	Date: <small>(Order is valid for one year)</small>	
My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.		
Notify patient we will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.		

Confidentiality statement: This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error, please notify the sender noted above and destroy all transmitted material.