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

VYVGART ORDER FORM

Date: ______________________ ICD-10 Code: ______________________

Patient Name: ______________________ Allergies: ______________________

Date of Birth: ______________________ 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 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. ✓ Max dose of 1200mg infusion.	***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: ______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 800-223-4063)

- 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.

Dispense as Written:

______________________ ______________
Prescriber Signature Date

Substitution Allowed:

______________________ ______________
Prescriber Signature Date

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