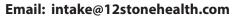
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





| VYVGART HYTRULO ORDER FORM | | | | | |
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| Date: ICD-10 Code: | | | | Therapy Status ☐ New Start | |
| Patient Name: | Allergies: | Allergies: | | | |
| Date of Birth: | Weight:Ibs OR | kg | Continuing Therapy: Last Dose: | | |
| PROVIDER INFORMATION | | | | | |
| Ordering Provider: | Provider Fax: | | | | |
| Provider NPI: | | Provider Address: | | | |
| Provider Phone: | | | | | |
| MEDICATION ORDER | | | | | |
| 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. To ourselve for infusion if no results are available, following labs will be drawn properties infusion: **The cycles may be ordered based on clinical evaluation.** **Positive AChR antibody te cycles of treatment infusion in the previous form the start of the previous first infusion: **Positive AChR antibody te cycles of treatment infusion in the previous form the start of the previous first infusion: **Positive AChR antibody te cycles of treatment infusion in the previous form the start of the previous first infusion: **Positive AChR antibody te cycles of treatment infusion in the previous form the start of the previous first infusion: **Positive AChR antibody te cycles of treatment infusion in the previous first infus | | | | 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 (needed for gMG indication only) | |
| PRE-MEDICATIONS | | | | | |
| Oral □ Acetaminophen:325mg500mg650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Ibuprofen:200mg400mg600mg □ Ondansetron:4mg8mg □ Other: | | IV □ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg □ Ondansetron:4mg8mg □ Other: | | | |
| LAB ORDERS (please indicate any labs to be drawn and frequency) | | 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 By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as m to payors with respect to this patient and prescription order. This enrollme | | y designated agent in submitting prior authorizations and other clinically required information | | | |
| Dispense as Written: | Substitution Allowed: | | | | |
| Prescriber Signature | | Prescriber Sigr | nature | Date | |