

**LAWRENCE COUNTY**  
**Memorial  Hospital**  
**DEACONESS ILLINOIS PARTNER**

PATIENT INFORMATION					
Name:			DOB:		
Allergies:			Date of Referral:		
REFERRAL STATUS					
<input type="checkbox"/> New Referral		<input type="checkbox"/> Dose or Frequency Change		<input type="checkbox"/> Order Renewal	
DIAGNOSIS AND ICDE 10 CODE					
<input type="checkbox"/> Myasthenia Gravis			ICD 10 Code: G70.00		
<input type="checkbox"/> Other: _____			ICD 10 Code: _____		
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)					
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number <small>Pt may be required to submit a pregnancy test prior to treatment</small>			<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Labs and tests supporting primary diagnosis <input type="checkbox"/> Acetylcholine Receptor Antibody test results (if Myasthenia Gravis)		
List of tried and failed therapies, including duration of treatment: _____					
MEDICATION ORDERS					
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____					
Medication	Dosing	Calculated Dose	Rate of Infusion	Diluent	Schedule
<input type="checkbox"/> J3590 Vyvgart	10mg/kg	Calculated dose based on current weight	Infusion over 1 hour	125ml NS	Weekly x4 weeks
<input type="checkbox"/> J3590 Vyvgart	1200mg	For patients weight greater than 120kg	Infuse over 1 hour	125ml NS	Weekly x4 weeks
Patient will be monitored for 1 hour post infusion **Subsequent treatment cycles to be at least 50 days from first dose of previous treatment.					
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> _____ doses					
PREMEDICATION/LABS					
<input type="checkbox"/> Acetaminophen _____ mg PO PRN		<input type="checkbox"/> CBC		<input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____	
<input type="checkbox"/> Benadryl _____ mg PO or IV		<input type="checkbox"/> CMP		<input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____	
<input type="checkbox"/> Methylprednisolone _____ slow IV push		<input type="checkbox"/> Other: _____ Date: _____			
<input type="checkbox"/> Other: _____					
ADDITIONAL ORDERS/INFORMATION					
<input type="checkbox"/> Administer via 0.2micron in line filter tubing					
<input type="checkbox"/> Utilize hypersensitivity standards of care					
PRESCRIBER INFORMATION					
Provider Name:					
Office Phone:		Office Fax:		Office Email:	
Prescriber Signature:				Date: _____ Time: _____	

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515  
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

**INFUSION ORDERS – VYVGART (EFGARTIGIMOD ALFA-FCAB)**