

PATIENT DEMOGRAPHICS

Insurance Information: Please attach copy of insurance card front and back (required)

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City/ST/Zip: _____
Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm

DIAGNOSIS*

ICD-10 CODE (required)

Please complete 2nd and 3rd digits to complete ICD-10 for billing

G61.81 Chronic Inflammatory Demyelinating Polyneuritis G70.00 Myasthenia Gravis without acute exacerbation
 Other: _____, ICD-10 _____ G70.01 Myasthenia Gravis with acute exacerbation

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-gyfc)	5.6mL (efgartigimod alfa 1,008mg and hyaluronidase-gyfc 11,200 units)	<input type="checkbox"/> Inject SC over 30-90 seconds once weekly x 4 doses. *Observe patient for 30 minutes after completion of injection.* <input type="checkbox"/> Repeat treatment cycle every _____ weeks x 1 year. (No sooner than 50 days from the start of the previous treatment cycle.)

Is patient currently receiving therapy above from another facility? NO YES
If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: Infusion Center Referring Physician
 No labs ordered at this time
 CBC q _____ CMP q _____ CRP q _____ ESR q _____ LFTs q _____ Other: _____

PRE-MEDICATION ORDERS:
 No premeds ordered at this time Diphenhydramine 25mg PO Other: _____
 Acetaminophen 650mg PO Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IV

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
Physician Name: _____ Provider NPI: _____ Specialty: _____
Address: _____ City/ST/Zip: _____
Contact Person: _____ Phone #: _____ Fax #: _____
Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

TEST RESULTS (required)

- Hepatitis B Screening for Ocrevus (submit results to start therapy)
- JC virus (JCV) antibody testing for Tysabri (submit results to start therapy and every 6 months to continue therapy)
 - Continuation labs to be done by: Infusion Center Referring Physician
- Meningococcal vaccination for Soliris (must be completed at least 2 weeks prior to starting therapy)

DIAGNOSTIC TEST RESULTS (please attach copy for all items checked)

For ALS:
 ALS Functional Rating Scale-revised (ALSFRS-r)
 Pulmonary function test

For CIDP:
 Electromyography (EMG) and Nerve conduction velocity (NCV) tests
 Lumbar puncture test
 Nerve biopsy report
 Neurological Rankin Scale Score

For MMN:
 Electromyography (EMG) and Nerve conduction velocity (NCV) tests
 anti-GM1 antibodies
 Lumbar puncture test

For Myasthenia Gravis:
 Acetylcholine receptor (AChR) antibodies
 Baseline MG-Activities of Daily Living (MG-ADL) Evaluation

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____	Dates of Treatment: _____	Reason for D/C: _____
Medication Failed: _____	Dates of Treatment: _____	Reason for D/C: _____
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