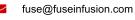
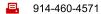


175MemorialHighway.Suite1-1 NewRochelle,NY 1080

914-460-489





ok the switch to biosimilar if insurance formulary prefers



Date:

VIVOIIII.			
PATIE	NT INFORMATION		
Name:	DOB: SEX: M F		
Allergies:	Date of Referral:		
PHYSIC	CIAN INFORMATION		
Physician Name*:	Practice Name:		
Address:	Office Contact*:		
Phone: Fax:	Email (for updates):		
REFE	ERRAL STATUS		
□New Referral □Referral Renewal □Medication/Order Change □Benefits Verification Only □Discontinuation Order			
VYVGART*: Dosing: 10 mg/kg IV weekly x 4 weeks			
Physician Signature	Date (Order is Valid for One Year) Infusion will be administered per MPP policy and protocols		
REQUIRED DIAGNOSIS:	REQUIRED DOCUMENTATION CHECKLIST:		
Myasthenia Gravis (gMg)	Patient Demographics		
* *			
Other	Insurance Card/Information		
	Clinical/Progress Notes supporting DX		
	Current Medication List and H&P		
Leat Inferior (Injection Date)	Positive AchR		
Last Infusion/Injection Date:			
STANDING LAB ORDERS: CMP CBC Frequence	су		
NOTES/ADDITIONAL COMMENTS:			
ORDERING PROVIDER			
Signature X	Date		
Provider	Phone Fax		