FUSE INFUSION

175MemorialHighway.Suite1-1
NewRochelle,NY
1080

914-460-489
fuse@fuseinfusion.com
914-460-4571

☐ _____ ok the switch to biosimilar if insurance formulary prefers

ORDER FORM VYVGART:

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION

Physician Name*:	Practice Name:
Address:	Office Contact*:
Phone: Fax:	Email (for updates):

REFERRAL 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:

_____ Myasthenia Gravis (gMg)

_____ Other_____

Last Infusion/Injection Date: _____

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

_____ Positive AchR

STANDING LAB ORDERS: _____ CMP _____ CBC Frequency _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____