

**Patient Information**

|   |                     |                                    |   |
|---|---------------------|------------------------------------|---|
| Patient Name:   |                     | DOB:                               |   |
| Patient Home Phone:                                       | Patient Cell Phone: | Patient Email:                     |   |
| Emergency/Alternate Contact Name:                         |                     | Emergency/Alternate Contact Phone: |   |
| NKDA  | Allergies:          | Weight lbs/kg:                     | Height:                                   |
| Patient Status:   | New to Therapy      | Continuing Therapy                 | Therapy Change                            |
|   |                     |                                    | Last infusion date (if applicable): _____ |
| Is the patient pregnant, planning a pregnancy or nursing: |                     | Yes                                | No  |
| Does the patient need interpreter services:               |                     | Yes                                | No  |

**Provider Information**

|                            |  |                             |             |
|----------------------------|--|-----------------------------|-------------|
| Referral Coordinator Name: |  | Referral Coordinator Email: |             |
| Ordering Provider:         |  | Provider NPI:               |             |
| Referring Practice Name:   |  | Phone:                      | Fax:        |
| Practice Address:          |  | City:                       | State: Zip: |

**ICD-10 CODE**

|  |  |
|--|--|
| G61.81 Chronic inflammatory demyelinating polyneuropathy | G70.01 Myasthenia gravis with (acute) exacerbation |
| G70.00 Myasthenia gravis without (acute) exacerbation    | Other: _____                                       |

**Medication Order**

|   |                                      |  |
|---|--------------------------------------|--|
| <b>Vyvgart</b> (efgartigimod alfa-fcab)                           | <b>Dose:</b> 10mg/kg IV<br>1200mg IV | <b>Frequency:</b> Once weekly for 4 weeks (1 treatment cycle) every 50 days<br>Other: _____                    |
| <b>Vyvgart Hytrulo</b> (efgartigimod alfa and hyaluronidase-qvfc) | <b>Dose:</b> 1008 mg/11200 units SC  | <b>Frequency:</b> Once weekly for 4 weeks (1 treatment cycle) every 50 days<br>Once every week<br>Other: _____ |

**Documentation Required (Note: Send all labs, must include specific labs listed here)**

|      |                                 |                     |                        |
|------|---------------------------------|---------------------|------------------------|
| Labs | Insurance Card (front and back) | Current Medications | History/Progress Notes |
|------|---------------------------------|---------------------|------------------------|

**Pre-Medication Order**

|                                |         |       |              |   |          |                  |    |    |
|--------------------------------|---------|-------|--------------|---|----------|------------------|----|----|
| <b>acetaminophen</b> (Tylenol) | 500mg   | 650mg | 1000mg PO    | <b>diphenhydramine</b> (Benadryl)       | 25mg     | 50mg /           | PO | IV |
| <b>cetirizine</b> (Zyrtec)     | 10mg PO |       |              | <b>methylprednisolone</b> (Solu-Medrol) | 40mg IV  | 125mg IV         |    |    |
| <b>loratadine</b> (Claritin)   | 10mg PO |       |              | <b>hydrocortisone</b> (Solu-Cortef)     | 100mg IV |                  |    |    |
| Other: _____                   |         |       |              |   |          |                  |    |    |
| Dose: _____                    |         |       | Route: _____ |   |          | Frequency: _____ |    |    |

**Special Instructions (Prior therapy, treatment dates, and reasons for d/c)**

Provider Name

Provider Signature

Date

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order

**Patient Information**

|                                   |                                    |      |   |   |          |   |   |
|-----------------------------------|------------------------------------|------|---|---|----------|---|---|
| Patient Name:                     | DOB:                               | Sex: | M | F | Fasting: | Y | N |
| Patient Home Phone:               | Patient Cell Phone:                |      |   |   |          |   |   |
| Emergency/Alternate Contact Name: | Emergency/Alternate Contact Phone: |      |   |   |          |   |   |

**Lab Test (Please circle or write in ICD-10)**

|                           |  |  |   |
|---------------------------|--|--|---|
| ALT                       | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21                      | HIV VIRAL LOAD                           | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20                       |
| AST                       | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21                      | IgE                                      | J45.4, J45.3, L50.9, J45.40, J45.50   |
| HEPATIC FUNCTION PANEL    | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21                      | IgG                                      | G35, G36.0  |
| BASIC METABOLIC PANEL     | I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9                           | IMMUNOGLOBULIN QUANT IgG, IgM, IgA       | G35, G36.0  |
| CALCIUM                   | M81.0, M81.8   | IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE  | G35, G36.0  |
| CBC (INCLUDES DIFF/PLT)   | I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1                          | IRON, TIBC, FER PNL                      | D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9                            |
| CBC (H/H, RBC, WBC, PLT)s | I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1                           | LIPID PANEL                              | Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2                        |
| COMP METABOLIC PANEL      | I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9                    | MAGNESIUM                                | I10, Z79.899, R25.2, E83.42, Z00.00   |
| CREATININE                | M81.0, M81.8, G35  | PSA                                      | R97.20, C61, N40.1, Z12.5, N40.0  |
| C-REACTIVE PROTEIN (CRP)  | R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50                       | PROTHROMBIN TIME-INR                     | Z79.01, I48.91, I48.0, Z51.81   |
| FERRITIN                  | D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9                                       | TRANSFERRIN SATURATION                   | D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9                            |
| G6PD                      | M1A.9XX0, M1A.9XX1   | QUANTIFERON TB GOLD                      | Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90 |
| GROWTH HORMONE            | E22, C7A.1, E34  | TSH                                      | E03.9, I10, E03.8, R53.83, E06.3, E05.00                                    |
| HBSAG CONFIRMATION        | Z11.3, Z36.9, Z20.2, Z11.59, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0          | URIC ACID                                | M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1                               |
| HEMOGLOBIN & HEMATOCRIT   | D50.9, D64.9, D50.0, D63.1, N18.9  | VIT B12/FOLIC ACID                       | M89.49, E53.8, R53.83, F41.8, F41.9, E05.00                                 |
| HEMOGLOBIN A1C            | E11.9, E11.65, R73.01, Z00.00, I10   | VIT D 25- HYDROX                         | E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8                           |
| HEP B SURF AG             | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0 | Miscellaneous Labs Not Listed (Write In) |   |
| HIV 4TH GEN               | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20                                  |  |   |
| HIV 1/2 AB DIFF           | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20                                  |  |   |

**Frequency**

Prior to each dose      Yearly      Other: Please Specify Below

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Provider Name \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider Phone \_\_\_\_\_

o 888.209.8874 aleracare.com advanced infusion centers™