vitalcare® of the FOUR STATES

IMMUNOGLOBULIN ORDER FORM

Vital Care of the Four States, 109 E Hickory St., Neosho, MO 64850
OFFICE 417-451-7900 / FAX 417-451-7915

DEMOGRAPHICS

Patient Name: _____

Address: _____

City: _____ State: ____ Zip:_____

DOB: ____/____/____ ☐ Male ☐ Female

Phone: _____

SSN: _____ Ht: _____ Wt: _____

PRESCRIBING PHYSICIAN

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

License#: _____

DEA#: _____NPI: _____

ALLERGIES / REACTIONS

_____

_____

Signature: _____

Date: _____

PHYSICIAN ORDERS

☐ **Vyvgart-Hytrulo** **REFILLS: _____**

☐ Myasthenia Gravis: 1008 mg efgartigimod alfa / 11,200 units hyaluronidase once weekly x 4 weeks
Repeat cycle every _____ weeks

☐ CIDP: 1008 mg efgartigimod alfa / 11,200 units hyaluronidase once weekly indefinitely

☐ **PRE-MEDICATIONS / LABS** **REFILLS: _____**

☐ Diphenhydramine 25 MG IV 15-30 minutes before infusion

☐ Solu-Medrol _____ MG IV — 30 minutes before infusion

☐ OTHER: _____

☐ LABS: _____

☑ **Anaphylaxis Kit per Pharmacy protocol**
TO BE ADMINISTERED BY THE HEALTH CARE PROVIDER **PRN** FOR PATIENTS RECEIVING IV MEDS IN THE HOME
Epinephrine Auto Injector 0.3mg/0.3ml IM – Repeat one time in 20 minutes if needed

ACCESS / MAINTENANCE:

☑ Subcutaneous injection with butterfly per healthcare provider over 60-90 seconds

DIAGNOSIS:

☐ **G70.00 Myasthenia Gravis without acute exacerbation**

☐ **G61.81 Chronic Inflammatory Demyelinating Polyneuropathy**