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 10mg/kg** **REFILLS: _____**

☐ IV once weekly for _____ weeks with _____ weeks between cycles

☐ **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

IV / ACCESS / MAINTENANCE:

- ☐ CENTRAL LINE - Flush with Normal Saline 10 ml before each bag of medication.
- ☐ Subcutaneous Port - Flush with Normal Saline 10 ml before each bag of medication.
- ☐ Peripheral IV - Flush with Normal Saline 5--10 ml with IV start and before & after medication

DIAGNOSIS:

- ☐ **G70.00 Myasthenia Gravis without acute exacerbation**
- ☐ **G61.81 Chronic Inflammatory Demyelinating Polyneuropathy**