



Fax Referrals To: (855) 891-2191  
 Email Referrals To: [referrals@vivoinfusion.com](mailto:referrals@vivoinfusion.com)  
 Have a Question? (855) 478-1528

VYVGART (efgartigimod alfa-fcab) ORDER FORM  
 (\* - Required Fields)

**STAT REQUEST**  
 (\*REASON MUST BE PROVIDED BELOW)

New Referral	Referral Renewal	Medication/Treatment Change
Benefits Verification Only		Discontinuation Order
<b>PATIENT INFORMATION</b>		
NAME*:		DOB*:
ADDRESS:		SEX:    M    F
WEIGHT:    LBS   KG	HEIGHT:	EMAIL:
ALLERGIES:		
<b>PHYSICIAN INFORMATION</b>		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL (FOR UPDATES):
VYVGART Infusion*: <i>(SELECT ONE OF THE FOLLOWING)</i>  10 mg/kg IV weekly x 4 weeks		ICD-10*:
Physician Signature* _____ *NPI # _____		Date*(Referral Valid for One Year) _____ <i>Infusion will be administered per VIVO policy and protocols</i>
<b>ICD-10 Description:</b>          *STAT REASON: (STAT requests will be assessed per VIVO policy and protocols)	<b>REQUIRED DOCUMENTATION CHECKLIST:</b>  Patient Demographics Insurance Card/Information Progress Notes supporting DX Current Medication List and H&P Positive AchR	
Last Infusion/Injection Date: _____		
STANDING LAB REQUEST (to be drawn by clinic):    CMP    CBC *Frequency _____		
Additional comments/notes:		

**Locations:**

-----Colorado-----

Lakewood

-----Florida-----

Jacksonville  
 Kissimmee  
 Port St. Lucie  
 Suncoast  
 Winter Park

-----Ohio-----

Beachwood  
 Middleburg Hts.  
 Painesville  
 Youngstown  
 Westlake  
 Fairlawn

-----Oklahoma-----

Tulsa

-----Texas-----

Arlington  
 Cedar Hill  
 Dallas  
 Denton  
 Ft. Worth  
 Irving  
 Rockwall  
 Southlake  
 Flower Mound  
 Plano  
 Tyler