Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Vyvgart Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (856) 996-0145
F. (856) 770-8271 ~ Attn: Stephanie D

Is this a Continuation of Care or a new start to the medication?

- ▢ Continuation of Care (Provide documentation of last administration)
- ▢ New Rx

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI Tax ID#	**Name: NPI: Tax ID#**
Fax Number	
Practice Contact (Name/Phone number)	
Email of Contact	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: Weight in lbs:	
Insurance(s): include copies of front and back	
Preferred Treatment Location	▢ Voorhees ▢ Moorestown ▢ Wall/Manasquan ▢ Sewell ▢ Hamilton ▢ Galloway

Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

Diagnosis:
☐ G70.00 Myasthenia gravis without (acute) exacerbation
☐ G70.01 Myasthenia gravis with (acute) exacerbation
☐ Generalized myasthenia gravis (gMG) anti-acetylcholine receptor (AChR) antibody positive
☐ Other: _____

The following information is required for authorization for persistent allergic asthma:

- Is the patient anti-acetylcholine receptor antibody positive (AChR-Ab+)? ☐ YES ☐ NO
    - If yes, please provide documentation/results.
- What Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of disease does the patient have? _____
- What is the score of the patient's Myasthenia Gravis Activities of Daily Living (MG-ADL)? _____
- What percentage of the MG-ADL score is due to non-ocular symptoms? _____
- Is the patient receiving a stable dose of ≥ 1 of acetylcholinesterase inhibitor(s), steroids, or NSIST? _____
    - If yes, which therapy/ies and for how long?
      _____
- Which conventional therapies has the patient had an inadequate response to? _____
- Has the patient required chronic plasmapheresis or plasma exchange therapy? ☐ YES ☐ NO
- Will the patient have concomitant treatment with rituximab, eculizumab or immunoglobulins? ☐ YES ☐ NO
- Please submit the patient's IgG levels.
- Please submit the patient's objective signs of neurologic weakness exams (such as QMG score).

PLEASE NOTE:

- Please include a copy of RX to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required.

    - ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
    - *OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS*
    - *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- **!! IMPORTANT !!** *Please notify our office if the medication is discontinued.*

Ordering Provider Signature: _____