

Vyvgart (efgartigimod alfa-fcab) ORDER FORM

Prerequisites to treatment – ensure the following information is complete and attached with

referral: Demographics Prior Authorization Office/Progress Notes**PATIENT INFORMATION**Patient Name: _____ D.O.B. _____ Male Female

Phone Number: _____ Allergies: _____

DIAGNOSIS Myasthenia Gravis ICD 10: _____ Other: _____ ICD 10: _____**PRE-MEDICATION** Tylenol 1000mg PO Solu-Medrol 40mg IVP
 Cetirizine 10mg PO Solu-Medrol 125mg IVP
 Diphenhydramine 25mg PO Other: _____**MEDICATION****Vyvgart***Dosing:* IV 10mg/kg (Max dose 1200mg per Infusion)*Duration:* IV infusion over 1 hour OR IV infusion over _____ hour*Frequency:* Weekly x 4 consecutive weeks*Route:* Peripheral IV per protocol PICC capping per protocol PORT capping per protocol Monitor vitals baseline and post infusion Other: _____ New Start Continuation of Therapy Date of Last Dose (if applicable) _____

REFERRING PROVIDER INFORMATION

For questions regarding patient's care during the infusion, please contact:

Facility: _____ Fax: _____

Name 1st Point of Contact (must be available during infusion): _____

Phone: _____

Name 2nd Point of Contact (must be available during infusion): _____

Phone: _____

By referring to the Medical Associates Infusion Clinic, it is recognized and agreed upon that the referring specialist or delegate listed above will be available and responsive during the duration of the scheduled infusion appointment. This contact should be available to answer any questions and/or address concerns related to the care of the patient. The on-site provider within the Infusion Clinic will be responsible for urgent patient care needs during the infusion.

Ordering Provider Name (please print): _____

Ordering Provider Signature: _____ Date: _____

FAX NUMBER: 563-584-4232

PHONE NUMBER: 563-584-4370

Order valid for 1 year from date of signature unless otherwise specified.