Local Infusion

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VYVGART (EFGARTIGIMOD ALFA-FCAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments:_____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Myasthenia Gravis (without acute exacerbation), ICD 10: G70.00

❑ Myasthenia Gravis with acute exacerbation, ICD 10: G70.01

❑ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

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

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Famotidine 20 mg IV

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Benadryl 25mg PO

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE / FREQUENCY	ROUTE
Vyvgart	10 mg/kg once weekly for 4 consecutive weeks Max dose of 1200mg per infusion	IV

May be repeated based on clinical evaluation and patient response; the interval between treatment cycles may be individualized by the prescriber, including initiation of a subsequent cycle as early as 7 days after the last infusion of the prior cycle.

Treatment cycle/interval: _____

Prescriber may adjust treatment-cycle frequency based on clinical response.

LABS / SPECIAL INSTRUCTIONS