Local Infusion

MYLOCALINFUSION.COM

VYVGART (EFGARTIGIMOD ALFA-FCAB) ORDER FORM

PATIENT INFORMATION

Patient Name: ______________________________ DOB: __________

Mobile Number: ______________________ Patient Weight: ______________________

Allergies: ____

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 every 4 weeks per protocol Max dose of 1200mg per infusion	❑ IV

Subsequent treatment cycles will require a new order

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): __________

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❑ NH: 603.217.5371 ❑ ME: 207.407.7272

Order valid for 1 year from date of signature unless otherwise specified here: __________