

VYVGART (EFGARTIGIMOD ALFA-FCAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____ kg
 Allergies: _____
 Patient has known difficult venous access. Comments: _____

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

I authorize _____ additional cycles of treatment.

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

LABS / SPECIAL INSTRUCTIONS

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

FAX NUMBERS:

- CT: 203.433.0621
- MA: 413.296.8482
- NC: 919.984.8698
- NY: 631.250.6020
- SC: 864.973.6279
- FL: 904.877.9270
- MD: 240.224.8607
- NH: 603.217.5371
- OH: 937.871.4594
- VA: 703.202.0499
- ME: 207.407.7272
- NJ: 201.581.4521
- PA: 610.273.5998