

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	<input type="checkbox"/> 10 mg/kg once weekly for 4 consecutive weeks Max dose of 1200mg per infusion	<input type="checkbox"/> IV

Subsequent treatment cycles will require a new order, and will be initiated 50 days from the start of the previous treatment cycle unless otherwise directed.

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

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: CT: 203.433.0621 ME: 207.407.7272 NH: 603.217.5371 NJ: 201.581.4521

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