

# VYVGART

Please include the following to expedite the order:

Patient Demographics, Insurance Information, Labs

## PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: ☐ M ☐ F ☐ Other \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

## PRESCRIBER

Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_ State License: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## CLINICAL

Diagnosis: ☐ G70.00 (MG w/o [acute] exacerbation) ☐ G70.01 (MG w/ [acute] exacerbation)

Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ ☐ kg ☐ lbs Height: \_\_\_\_\_ ☐ cm ☐ in

CBC Completed: ☐ Yes ☐ No CMP/LFTs Completed: ☐ Yes ☐ No

Please attach lab results to referral

AChR antibody positive test: ☐ Positive ☐ Negative Date: \_\_\_\_\_

## TREATMENT

VYVGART (efgartigimod alfa)

Route: Intravenous infusion

Dose: ☐ 10mg/kg (max 1200mg)

Frequency:

☐ Once weekly for 4 weeks\*

*\*One treatment cycle. Subsequent cycles may require additional insurance authorization. Treatment cycles will be given 50 days from the start of the previous treatment cycle.*

Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

Premedication Protocol: (Not Usually Indicated)

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Methylprednisolone: ☐ 40mg ☐ 125mg IV

☐ Other: \_\_\_\_\_

Sig: \_\_\_\_\_

☒ Center will use anaphylactic and hypersensitivity protocol established by Restore Health

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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