MRN:_____

DOB: _____

Standard Plan of Treatment for Vyvgart™ (efgartigimod alfa-fcab)

NOTE: *Patient may be ineligible to receive Vyvgart™ if receiving antibiotics for active infectious process, antifungal therapy, fever and/or suspected infection, and/or recent or planned surgery.*

1. **Patient Name**: _____Height (in.):_____ Weight (lbs):_____

2. **Allergies**: _____

3. **Primary Diagnosis:**

   Myasthenia Gravis: ☐ G70.00 without acute exacerbation ☐ G70.01 with acute exacerbation

4. **Order:**

   Patients weighing less than 120kg: Vyvgart™ 10mg/kg administered as an IV infusion over one hour once weekly for 4 weeks.

   Patients weighing 120kg or more: Vyvgart™ 1200mg administered as an IV infusion over one hour once weekly for 4 weeks.

Special Orders: _____

Administer with a 0.2 micron filter. Flush entire infusion line with 0.9% sodium chloride. Monitor patient for one hour after completion of infusion.

Lab orders with infusion: _____

_____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

5. **Physician's Signature**:_____/_____ **Date**: _____
   (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

6. ***Fax updated supporting clinical MD notes with each order renewal or change in orders***

MRN:_____
DOB: _____

Guidelines for Prescribing Vyvgart™ (efgartigimod alfa-fcab)

(Required documentation with all initial referrals)

Patient Name: _____ Referral Date: _____

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-6)*

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Include supporting clinical MD notes that include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy. Any documented use and response to azathioprine, methotrexate, cyclosporine, mycophenylate, etc. Include positive serologic test for anti- AChR antibodies, any abnormal neuromuscular single-fiber electromyography (SFEMG), nerve stimulation studies, positive anticholinesterase test or other test/labs to support diagnosis.**

- **VYVGART is a neonatal Fc receptor blocker indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.**

☐ Other as requested: _____

_____

Required Pre-Screening:

☐ Positive serologic test for anti-AChR antibodies

Warnings and Precautions

- Infections: Delay administration of VYVGART to patients with an active infection. Monitor for signs and symptoms of infection in patients treated with VYVGART. If serious infection occurs, administer appropriate treatment and consider withholding VYVGART until the infection has resolved. (5.1)
- Hypersensitivity Reactions: Angioedema, dyspnea, and rash have occurred. If a hypersensitivity reaction occurs, discontinue the infusion and institute appropriate therapy. (5.2)

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.