

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/> Order Renewal	
Patient preferred clinic:			

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

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:	
Patient Name:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight:	LB or KG	Gender: Allergies: See list NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

<input type="checkbox"/>	G70.00 - Myasthenia Gravis without acute exacerbation
<input type="checkbox"/>	G70.01 - Myasthenia Gravis with acute exacerbation
<input type="checkbox"/>	- Other: _____

REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	MG-ADL Score/MGFA classification	THERAPY:	
6	IgG Level		
			Continue current order until insurance approved

MEDICATION ORDERS:

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.

DOSE:

Vyvgart™ 10mg/kg diluted in 125ml NS administered as an IV infusion over one hour once weekly for 4 weeks. (1 cycle)
 Note: Max dose of 1200mg will be given to patients with a weight greater than or equal to 120KG
Flush entire infusion line with NS. Monitor patient for one hour after completion of infusion.

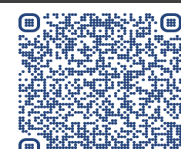
FREQUENCY:

Repeat cycle _____ weeks from date of last infusion; patient to receive _____ cycles
 Other: _____

SPECIAL/LAB ORDERS:

Refills x 12 months, if frequency is defined, unless noted otherwise here:

LINE USE/CARE ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.	
---	---	---

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

_____	_____	_____
Dispense as written/Brand medically necessary	Substitution permitted	