

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:		<input type="checkbox"/> See list	<input type="checkbox"/> NKDA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> 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	<b>IF ORDER CHANGE:</b>
5	MG-ADL Score/MGFA classification	THERAPY:	
6	Positive AChR antibody		
			<b>Continue current order until insurance approved</b>

### 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 20ml NS. Monitor patient for one hour after completion of infusion.**

**FREQUENCY: (Select for additional treatment cycles)**  
 Patient to receive \_\_\_\_ cycles. Treatment cycles will be given 50 days from the start of the previous treatment cycle.  
 OR, patient to receive \_\_\_\_ cycles. Repeat cycles \_\_\_\_ weeks from date of last infusion.  
**[4 weeks from date of last injection = 50 days from the start of the previous cycle]**  
 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 <input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.	
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### 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	