Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:	
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

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

Rev 4.30.25

PATIENT DEMOGRAPHICS:

Patient Name:					
Patient's Phone:		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)

☐	G70.00 - Myasthenia Gravis without acute exacerbation
☐	G70.01 - Myasthenia Gravis with acute exacerbation
☐	_____- 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 REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	MG-ADL Score/MGFA classification		☐ **Continue current order until insurance approved**
6	Positive AChR antibody		

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:

☑ Start PIV/Access CVC
☑ Flush device per facility standard flushing procedure
☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.

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	