

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

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:		<input type="checkbox"/> See list	<input type="checkbox"/> 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	Positive AChR antibody		
			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 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.
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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	



Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- 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.**

Palmetto Infusion 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.palmettoinfusion.com