

# Vyvgart (Efgartigimod alfa-fcab)

**PATIENT INFORMATION**Referral Status (check one):  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

NKDA  Allergies: \_\_\_\_\_ Weight \_\_\_\_\_ Please specify:  lbs  kg Height: \_\_\_\_\_Patient Status (check one):  New to Therapy  Continuing Therapy | Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

**PRESCRIPTION****THERAPY ADMINISTRATION**

- Efgartigimod alfa-fcab** (Vyvgart)
  - Dose: 10 mg/kg (patients weighing 120 kg or more, the recommended dose is 1200mg)
  - Frequency: once weekly for four weeks (one treatment cycle)
  - Route: Intravenous
- Select for additional treatment cycles. \_\_\_\_\_  
(Indicate number of cycles)
  - Subsequent cycles may require additional insurance authorization.
  - Treatment cycles will be given 50 days from the start of the previous treatment cycle.
- Dilute with 0.9% Sodium Chloride Injection, USP prior to administration
- Administer as an intravenous infusion over one hour via a 0.2 micron in-line filter
- Monitor patients during administration and for one hour there after for clinical signs and symptoms of hypersensitivity reactions  
(Order will expire one year from date signed)

**SPECIAL INSTRUCTIONS****PROVIDER INFORMATION**

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\_\_\_\_\_  
Provider Name (Print)\_\_\_\_\_  
Provider Signature\_\_\_\_\_  
Date