medix infusion

# Vyvgart Order Form
## (efgartigimod alfa-fcab)

**FAX TO: 972.499.9210**

## PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

**Patient Preferred Location:** _____

## <ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

**ICD 10 Code**

☐ G70.00 Generalized Myasthenia Gravis, w/o Acute Exacerbation

☐ G70.01 Generalized Myasthenia Gravis, w/ Acute Exacerbation

Other: _____

**Prescribing Information**

Administer subsequent treatment cycles based on clinical evaluation; the safety of initiating subsequent cycles sooner than 50 days from the start of the previous treatment cycle has not been established.

***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. Some payors require MGFA Clinical Classification of II, III, or IV as well as MG-ADL total score ≥ 5 at initiation of therapy.**
***LAB RESULTS*: Positive serologic test for anti-AChR antibodies.**

## PRESCRIPTION

**Pre-Medications**

☐ Cetirizine: 10 mg PO

☐ Diphenhydramine: 25 mg PO

☐ Diphenhydramine: 25 mg IVP

☐ Methylprednisolone: 125 mg SIVP

Other: _____

**Vyvgart (efgartigimod alfa-fcab)**

Dilute in 0.9% Sodium Chloride for a total volume of 125 mL and infuse using 0.2-micron filter

**Dose:**
**IV:** (wt < 120 kg) Infuse 10 mg/kg over 1 hour every week for 4 weeks
**IV:** (wt ≥ 120 kg) Infuse 1200 mg (3 vials) over 1 hour every week for 4 weeks

**Patient Weight:** _____ lbs **or** _____ kg

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

**Post Treatment Observations:** The patient is observed for 1 hour following each infusion.

**Comments:**

_____

_____

_____

_____

_____

## PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____