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)

☐ **IV:** Infuse 10 mg/kg in 125 mL 0.9% Sodium Chloride over 1 hour every week for 4 weeks **(1 cycle)**

***Max dose 1200 mg for patients weighing 120 kg or greater**

VYVGART HYTRULO (efgartigimod alfa and hyaluronidase-qvfc) ***SQ formulation of Vyvgart***

☐ **SQ:** Administer 1008 mg / 11,220 units subcutaneously over 30 - 90 seconds every week for 4 weeks **(1 cycle)**

Frequency

☐ Repeat cycle above _____ weeks from date of last infusion*; Patient to receive _____cycles

Other: _____

** Prescribing Info states the safety of initiating subsequent treatment cycles sooner than 50 days from the start of previous treatment cycle has not been established.*

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

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

Comments:

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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