

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex: M F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ lbs kg  
 Primary Language: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Patient Preferred Location: \_\_\_\_\_

## DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

### 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  $\geq 5$  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: \_\_\_\_\_

### YYVGART (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**

### YYVGART 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.*

Is the patient on any other disease modifying therapy? Yes No

If yes, please note therapy and last dose: \_\_\_\_\_

**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: \_\_\_\_\_