

VYVGART™ (efgartigimod alpha-fcab) Referral Form

Please complete the following and fax with clinical documentation to: 720.279.7461

Referral Process	
1. PATIENT INFORMATION (*indicates a required field)	2. PHYSICIAN INFORMATION (*indicates a required field)
Name*: _____	Physician's name*: _____
Address*: _____	License #: _____ NPI #: _____
City*: _____ State*: _____ Zip*: _____	DEA #: _____ Email*: _____
Home Phone: _____ Mobile Phone*: _____	Address*: _____
Email*: _____	City*: _____ State*: _____
Primary language*: _____	Zip*: _____
DOB*: _____ Social Security #: _____	Office Contact: _____
Gender*: <input type="checkbox"/> M <input type="checkbox"/> F Height: _____ Weight*: _____	Phone*: _____ Fax*: _____
Allergies*: _____ NKA*: <input type="checkbox"/>	Specialty*: _____
AChR test results <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Alternate contact name: _____ Alternate contact phone: _____	
Consent to leave voice message at the patient and/or alternate contact phone <input type="checkbox"/> Yes <input type="checkbox"/> No*	
3. DIAGNOSIS (*indicates a required field) Year of diagnosis: _____	
*ICD10 Code: <input type="checkbox"/> Myasthenia Gravis w/o acute exacerbation (G70.00) <input type="checkbox"/> Myasthenia Gravis with acute exacerbation (G70.01)	
<input type="checkbox"/> Other diagnoses: _____	
4. INSURANCE INFORMATION Please submit copies of the front and back of primary and secondary insurance cards with this referral.	
5. PRESCRIPTION INFORMATION Anticipated Start Date: _____	
Prescription* : VYVGART 400 mg/20 mL (20 mg/mL) solution in a single-dose vial for intravenous use Prior to administration, dilute VYVGART in 0.9% Sodium Chloride Injection, USP to make a total volume to be administered of 125mL	
<input type="checkbox"/> Initial cycle: 10 mg/kg per intravenous infusion weekly over one hour for 4 weeks* administered by a healthcare professional. In <i>patients weighing 120 kg or more</i> , the recommended dose of VYVGART is 1200 mg per infusion. Flush IV tubing with a minimum of 20 mL 0.9% Sodium Chloride solution after completion of VYVGART infusion.	
*Subsequent treatment cycles must be based on clinical evaluation and no sooner than 50 days from the start of the previous treatment cycle.	
Additional orders: _____	
Access: <input type="checkbox"/> Peripheral Other: _____	
6. FLUSH ORDERS	
Skilled nursing may insert and remove PIV, access CVC, or access/deaccess Port as needed	
<input type="checkbox"/> PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 mL NS, followed by Heparin 2-5 mL 10 units/mL if indicated	
<input type="checkbox"/> Port: Flush before, after each infusion, and as needed with 5-20 mL NS, followed by Heparin 100 unit/ml 5 mL.	
7. ANAPHYLAXIS ORDERS	
Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.	
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.	
If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs	
8. Skilled nursing to assess patient, administer medication, and monitor for recommended time post-infusion	
PHYSICIAN'S SIGNATURE (required): _____ Date: _____	