VEROS HEALTH
Excellence in Complex Care

VYVGART™ (efgartigimod alpha-fcab) Referral Form

Please complete the following and fax with clinical documentation to: 720.870.2414

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*: _____ Primary language*: _____	City*: _____ State*: _____ Zip*: _____
DOB*: _____ Social Security #*: _____	Office Contact: _____
Gender*: ☐ M ☐ F Height: _____ Weight*: _____	Phone*: _____ Fax*: _____ Specialty*: _____

Allergies*: _____ NKA*: ☐

AChR test results ☐ Positive ☐ Negative

Alternate contact name: _____ Alternate contact phone: _____

Consent to leave voice message at the patient and/or alternate contact phone ☐ Yes ☐ No*

3. DIAGNOSIS (*indicates a required field) Year of diagnosis: _____

*ICD10 Code: ☐ Myasthenia Gravis w/o acute exacerbation (G70.00) ☐ Myasthenia Gravis with acute exacerbation (G70.01)

☐ 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

☐ Initial cycle: 10 mg/kg per intravenous infusion weekly over one hour for 4 weeks* administered by a healthcare professional. In ***patients weighing 120 kg or more***, 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: ☐ Peripheral Other: _____

6. FLUSH ORDERS

Skilled nursing may insert and remove PIV, access CVC, or access/deaccess Port as needed

☐ **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

☐ **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:** _____

Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.