Site of Care

☐ Home Infusion
☐ Infusion Center
☐ Doctor's Office

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

VYVGART (EFGARTIGIMOD ALFA-FCAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Mobile Number: _____

Patient Weight: _____ Patient Height: _____ Allergies: _____

Other Medications: _____

DIAGNOSIS (Provider must specify)

☐ Myasthenia Gravis without acute exacerbation, ICD10: G70.00

☐ Myasthenia Gravis with acute exacerbation, ICD10: G70.01

☐ Other: _____

Prior to treatment – ensure the following information is complete and attached with referral:

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Benadryl 25 mg PO ☐ Methylprednisolone (Solu-Medrol) _____ mg IVP

☐ Other: _____ Dose: _____

☐ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Vyvgart	☐ 10 mg/kg once weekly for 4 consecutive weeks Max dose of 1200mg per infusion ☐ Other: _____	IV	Subsequent treatment cycles will require a new order and will be initiated 50 days from the start of the previous treatment cycle unless otherwise directed.

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS/SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

PROVIDER INFORMATION

Provider Name: _____ Provider NPI: _____ Contact: _____

Phone: _____ Fax: _____ Email Address: _____

Signature: _____ Date: _____