Phone and Fax: 608-690-7210
www.MySmartInfusion.com

Vyvgart (efgartigimod alfa-fcab)
Infusion Order Form

Patient Information

Patient Name: ____DOB: _____________________ M ☐ F ☐

Allergies: ____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____________ Next Due Date: _____________

Diagnosis and ICD 10 Code (Required)

☐ Generalized Myasthenia Gravis (gMG)
Anti-Acetylcholine Receptor (AChR) antibody positive ICD 10 Code: G70.00

Vyvgart Medication Order

Patient Weight: _____________ KG

Dosage

☐ 10mg/kg

☐ 1200mg

Frequency

☐ Every 4 weeks

Nursing

Provide nursing care per Smart Infusion Nursing Procedures, Including reaction management and post-procedure observation.

Special Instructions / Notes

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ MG- ADL Assessment
☐ EMG-Confirming MG
☐ Clinical & Progress Notes (including last infusion note)
☐ Copy of Insurance Card (front/back)

Location

☐ Eau Claire ☐ Weston ☐ Middleton

Provider Information

Provider Name: ____ Provider NPI: _______________________

Office Phone: ______________________________________ Office Fax: _____________________________________

Provider Signature: ____ Date: _____________________