



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

Other: _____ ICD 10 Code: _____

Nursing

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

Special Instructions / Notes

Vyvgart Medication Order

Patient Weight: _____ KG

Dosage

10mg/kg
 1200mg

Frequency

Every 4 weeks

Required Documents

Patient Demographic Sheet
 H & P within the past 6 months
 Current Medication List
 Clinical and Progress Notes

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____