Phone: (847) 324-6800 Fax: (224) 251-7141 Email: intake@infusacare.com

InfusaCare Medfuse

Vyvgart (Efgartigimod alf-fcab) Infusion Order

Patient Name: DOB: □ Male □ Female

Diagnosis (please provide ICD10 code):

□ Other:

□ NKDA □ Allergies:

□ New Therapy Order □ Continuation of Therapy Date of last dose:

Ordering Provider Name:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

Pre-Medication

□ Acetaminophen _____mg by □ PO
□ Ceterizine _____mg by □ PO
□ Diphenhydramine _____mg by □ PO/ □ IVP
□ Solu-Medrol _____mg by □ PO/ □ IVP
□ Solu-Cortef _____mg by □ PO/ □ IVP
□ Other:

Vyvgart is a weight based drug:

Patient Height (cm):
Patient Weight (kg):

Required Documentation:

□ Patient Demographics
□ Patient Insurance (med and pharm card copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□ Lab results for CBC and CMP
□ Hepatitis B panel
□ Quantiferon test results
□ Brain MRI within one year
□ ACH Antibody positive
□ Other:

□ **Vyvgart Medication Order**

- Dosage and Frequency (choose one)
  - □ 10 mg/kg (< 120 kg) once weekly for 4 weeks
  - □ 1200 mg (> 120 kg) once weekly for 4 weeks
- Refills (choose one)
  - □ None
  - □ Repeat for _____ cycles. Subsequent cycles start 50 days from day 1 of previous cycle based on clinical evaluation.

Additional Instructions/Notes:

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____