Efgartigimod alfa-fcab (Vyvgart)

Provider Order Form *rev. 10/12/2022*

Fax Form to: 330-294-2082

INDY INFUSION

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care, including reaction management and post procedure observation

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

☑ **efgartigimod alfa-fcab** (Vyvgart)
- Dose: 10 mg/kg (patients weighing 120 kg or more, the recommended dose is 1200mg)
- Frequency: once weekly for four weeks (total of four infusions)
- ☑ Dilute with 0.9% Sodium Chloride Injection, USP prior to administration
- ☑ Administer as an intravenous infusion over one hour via a 0.2 micron in-line filter

☑ Monitor patients during administration and for 1 hour thereafter for clinical signs and symptoms of hypersensitivity reactions

☑ Order is valid for 4 total infusions
(Order will expire one year from date signed)

Administer subsequent treatment cycles based on clinical evaluation; the safety of initiating subsequent cycles sooner than 50 days from the start of the previous treatment cycle has not been established.

Provider Name (Print) **Provider Signature** **Date**

Please include the following information when submitting a referral for Vyvgart:

* Supporting clinicals that show the patient is AChR antibody positive