



Vyvgart

Provider Order Form

PATIENT INFORMATION

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Address:	City:	State:	Zip Code:
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
Last infusion date (if applicable):			

REQUIRED DOCUMENTATION

Labs Insurance Card (front and back) Current Medications History/Progress Notes

ICD-10 CODE

G61.81 Chronic inflammatory demyelinating polyneuritis G70.01 Myasthenia gravis with (acute) exacerbation
 G70.00 Myasthenia gravis without (acute) exacerbation Other: _____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol)	500mg	650mg	1000mg PO	Diphenhydramine (Benadryl)	25mg	50mg	PO	IV
Cetirizine (Zyrtec)	10mg PO			Methylprednisolone (Solu-Medrol)	40mg IV	125mg IV		
Loratadine (Claritin)	10mg PO			Hydrocortisone (Solu-Cortef)	100mg IV			
Other: _____				Dose: _____		Route: _____		Frequency: _____

MEDICATION ORDER

Vyvgart (efgartigimod alfa-fcab)	Dose:	10mg/kg IV 1200mg IV	Frequency:	Once weekly for 4 weeks (1 treatment cycle) every 50 days Other: _____
Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)	Dose:	1008 mg/11200 units SC 1200mg IV	Frequency:	Once weekly for 4 weeks (1 treatment cycle) every 50 days Once every week Other: _____

PROVIDER INFORMATION

Provider Name:	Provider Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.