



HERITAGE
BIOLOGICS

Efgartigimod alfa-fcab (Vyvgart) Patient Referral Form

Admissions Fax # 844-878-6917

Admissions Phone # 855-WE-R-RARE (855-937-7273)

Patient Demographics Information

Patient Name		SSN#	DOB
Patient Address			
Primary Phone	Cellular Phone	Work Phone	
Emergency Contact Name, Relationship		Emergency Contact Phone Number	

Additional Documentation Needed

- Copy of insurance cards
- Patient face sheet w/demographics
- History and Physical
- CBC w/diff, BMP, & CMP
- Recent vitals including blood pressure

Patient Insurance Information

Insurance Plan #1	Insurance Plan #2		
Plan Address	Plan Address		
Plan Phone & Fax Numbers	Plan Phone & Fax Numbers		
Subscriber Name	DOB	Subscriber Name	DOB
Policy Number	Group ID	Policy Number	Group ID

Patient Clinical Information

Gender	Height (inches)	Weight (lbs.)	Allergies (food/drug)
<input type="checkbox"/> M <input type="checkbox"/> F			

Statement of Medical Necessity / Primary Diagnosis

ICD10:	Description of diagnosis:

Medication Information / Prescription and Orders

Medication: Vyvgart	Directions: Infuse IV per manufacturer guidelines OR over _____ hours. Titration rate according to package insert. Dilute Vyvgart dose in Sodium Chloride 0.9% to a final volume of 125 mL.	*If subsequent treatment cycles only Date of last infusion:
Treatment cycle <input type="checkbox"/> _____ mg (10mg/kg) IV weekly x4 weeks, #QS <input type="checkbox"/> Refills: _____ <input type="checkbox"/> Repeat cycle every _____ days (Repeat starting from day one of previous cycle)		Next dose due:

Line Access

- RN to start peripheral IV or use existing CVC. RN to administer catheter flushing 2-10 mL IV as needed for infusion and line maintenance.
- 0.9% Sodium Chloride Heparin 10 units/ml Heparin 100 units/ml 0.9% Sodium Chloride Sterile (port)

Quantity/Refills

Dispense:
quantity #QS + PRN refills
unless otherwise noted
 Other

Adverse Reaction Orders

In the event of an infusion reaction (ie: musculoskeletal pain, fevers, chills, rigors, headache) the following orders will be followed and physician will be notified.

- Mild/Moderate reaction: Pause infusion for 10 minutes, resume infusion at previously tolerated rate. Notify Pharmacist.
- Severe reaction (w/breathing problems): CALL 911, administer Epinephrine 0.3 mg IM.

Prescriber Information

Physician Name	Office Contact		
Practice Address	Practice Phone		
NPI#	License #	DEA#	
Physician Signature Required - Substitution Permitted	Date	Physician Signature Required - Dispense as Written	Date