# Efgartigimod alfa-fcab (Vyvgart) Patient Referral Form

## 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 ☐M ☐F | Height (inches) | Weight (lbs.) | Allergies (food/drug) |
|---|---|---|---|

## 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

☐_____ mg (10mg/kg) IV weekly x4 weeks, #QS

- ☐ Refills: _____
- ☐ 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 and medications per Heritage Biologics policy.**
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 |