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	
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:

Next dose due:

Treatment cycle

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

☐ Refills: ______

☐ Repeat cycle every ______ days
(Repeat starting from day one of previous cycle)

Line Access

RN to start peripheral IV or use existing CVAD. RN to administer catheter flushing and medications per Heritage Biologics policy.

☐ Sodium Chloride 0.9% 10 mL Flush: Flush with 2-10 mL sodium choride 0.9% IV before and after medication administration or every 24 hours while IV access in place.

☐ Sodium Chloride 0.9% 10 mL STERILE Flush: Flush with 5-10 mL STERILE sodium chloride 0.9% IV as needed for port access.

☐ Heparin Lock 100U/mL 5 mL Flush: Lock with 5 mL heparin 100U/mL after each use or daily while port accessed.

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