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	
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 CVAD. RN to administer catheter flushing and medications as directed.
☐ 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