

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

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

Statement of Medical Necessity / Primary Diagnosis

ICD10:	Description of diagnosis:
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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

Line Type: ☐ PIV ☐ Port/CVAD

- RN to start peripheral IV or use existing CVAD. RN to administer catheter flushing and medications per orders below.
- ☐ Sodium Chloride 0.9% 10 mL Flush: Flush with 2-10 mL sodium chloride 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.

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.

Quantity/Refills

Dispense:
Quantity #QS + PRN refills
unless otherwise noted
☐ Other

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