MIC | METRO INFUSION CENTER

INFUSION ORDERS - VYVGART™ (efgartigimod alfa-fcab)

PATIENT INFORMATION		
Name:	DOB:	Dosing Wt: _____ **Max dosing weight will be 120kg
Allergies:	Date of Referral:	☐ Change dose for weight change greater than 10%

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICD 10 CODE
☐ Generalized myasthenia gravis (gMG) anti-acetylcholine receptor (AChR) antibody positive ICD 10 Code: 670.00
☐ Other: _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information	☐ Clinical/Progress notes supporting primary diagnosis ☐ Labs and Tests supporting primary diagnosis ☐ _____
List Tried & Failed Therapies, including duration of treatment: 1) 2)	

MEDICATION ORDERS					
Medication	**Dosing**	**Calculated Dose**	**Rate of infusion**	**Diluent**	**Schedule**
VYVGART™ (efgartigimod alfa-fcab)	10mg/kg	_____mg Calculated dose based on dosing weight	Infuse over 1 hour	125ml Ns	*Weekly x 4 weeks
VYVGART™ (efgartigimod alfa-fcab)	10mg/kg	☐ 1200 mg For patient's weight greater than 120kg	Infuse over 1 hour	125ml Ns	*Weekly x 4 weeks
VYVGART™ (efgartigimod alfa-fcab)	10mg/kg	_____mg Calculated dose based on dosing weight	Infuse over 1 hour	125ml Ns	**Weekly x _____
*First dose to be given: _____ ** Subsequent treatment cycles to be at least 50 days from the start of the first cycle					

ADDITIONAL ORDERS
☐ Utilize hypersensitivity standards of care
☐ Monitor patient for 1 hour post infusion for signs of infusion reaction (as per PI)
Administration via a 0.2 micron in-line filter

PHYSICIAN INFORMATION		
Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164