**Efgartigimod alfa-fcab (Vyvgart )**

MIC | METRO INFUSION CENTER

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

**Infusion Office Preference:** _____

| **PATIENT INFORMATION** | | | |
|---|---|---|---|
| Date: | Patient Name: | | DOB: |
| ☐ NKDA Allergies: | | | |
| Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date: | | | Next Due Date: |
| **PROVIDER INFORMATION** | | | |
| Office Contact Name: | Office Email: | | |
| Prescribing Providers Name: | Provider NPI: | | |
| Office Address: | City: | State: | Zip: |
| Office Phone Number: | Office Fax Number: | | |
| **DIAGNOSIS AND ICD 10 CODE** | | | |
| ☐ Generalized myasthenia gravis (gMG) anti-acetylcholine receptor(AChR)antibody positive<br>☐ Other: _____ | ICD 10 Code: G70.00<br><br>☐ ICD 10 Code: _____ | | |
| **REQUIRED DOCUMENTATION/Testing** | | | |
| ☐ This signed order form by the provider<br>☐ Patient demographics AND insurance info<br>☐ Clinical/Progress notes supporting primary dx | ☐ anti-acetylcholine receptor (AChR) antibody result | | |
| List Tried & Failed Therapies 1) | 2) | | |
| **MEDICATION ORDERS** | | | |
| Weight _____(lbs/kg) | ☐ Vyvgart 10 mg/kg IV weekly x4 weeks (1 cycle) | | |
| Weight greater than 120 kg | ☐ Vyvgart 1200 mg IV weekly x4 weeks (1 cycle) | | |
| *Refills*: ☐ Select for additional treatment cycles. _____ (Indicate number of cycles)*<br>**(if not indicated order will only be utilized x1 cycle )*<br>*Subsequent treatment cycles to be at least 50 days from first dose of previous treatment* | | | |

| **SPECIAL INSTRUCTIONS** |
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**Provider Name (Print)** **Physician Signature:** **Date:**

**Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com**

All information contained in this order form is strictly confidential and will become part of the patient's medical record.