Vyvgart (Efgartigimod alfa-fcab)

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	ICD 10 Code: G70.00
☐ Chronic inflammatory demyelinating polyneuritis (CIDP)	☐ICD 10 Code: G61.81
☐ Other: _____	☐ ICD 10 Code: _____

REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx	☐ anti-acetylcholine receptor (AChR) antibody result
List Tried & Failed Therapies 1)	2)

MEDICATION ORDERS		
gMG dosing	Wt_____(lbs/kg)	☐ Vyvgart 10 mg/kg IV weekly x4 weeks (1 cycle)
	Wt greater than 120	☐ Vyvgart 1200 mg IV weekly x4 weeks (1 cycle)
gMG Refills: ☐ Select for additional treatment cycles. _____ (Indicate number of cycles) (if not indicated order will only be utilized x1 cycle). Subsequent treatment cycles to be at least 50 days from first dose of previous treatment		
CIDP dosing	Wt_____(lbs/kg)	☐ Vyvgart 10 mg/kg IV weekly
	Wt greater than 120	☐ Vyvgart 1200 mg IV weekly
CIDP Refills: ☐ X6 months ☐ X1 year ☐ Other: _____(if not indicated order will expire one year from date signed)		

SPECIAL INSTRUCTIONS

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.