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		
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			
Dosing	Wt_____(lbs/kg)	☐ Vyvgart 10 mg/kg IV weekly x4 weeks (1 cycle)	
	Wt more than 120 kg	☐ Vyvgart 1200 mg IV weekly x4 weeks (1 cycle)	
Refills: ☐ Select for additional treatment cycles. _____ (Indicate number of cycles) *(*subsequent cycles may require additional insurance authorization). Treatment cycles to be given 50 days from the start of the previous treatment cycle.*			

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.