INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Vyvgart *efgartigimod alfa-fcab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Myasthenia Gravis (without acute exacerbation), ICD 10: G70.00
☐ Myasthenia Gravis with acute exacerbation, ICD 10: G70.01
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Vyvgart	10 mg/kg once weekly for 4 consecutive weeks Max dose 1,200 mg per infusion	IV

May be repeated based on clinical evaluation and patient response; the interval between treatment cycles may be individualized by the prescriber, including initiation of a subsequent cycle as early as 7 days after the last infusion of the prior cycle. Prescriber may adjust treatment-cycle frequency based on clinical response.
Treatment cycle/interval: _____

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____