COMMUNITY HEALTH INTERVENTIONS SPECIALTY CLINIC

Community Health Interventions Specialty Clinic

INFUSION ORDERS - VYVGART™ (efgartigimod alfa-fcab)

PATIENT INFORMATION		
Name:	DOB:	Dosing Wt: _____ **Max dosing weight will be 120kg
Allergies:	Date of Referral:	

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: G70
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics AND insurance information	☐ 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-cab)	10mg/kg	The staff will calculate dose based on current weight.	Infuse over 1 hour	125ml Ns	*Weekly x 4 weeks
☐ VYVGART™ (efgartigimod alfa-cab)	1200 mg For patient's weight greater than 120kg		Infuse over 1 hour	125ml Ns	*Weekly x 4 weeks

*Patient will be monitored per PI for 1 hour post infusion.

** Subsequent treatment cycles to be at least 50 days from first dose of previous treatment.

ADDITIONAL ORDERS
☐ Order active for 6 months
☐ Order active for 1 year
☐ Utilize hypersensitivity standards of care
Administration via a 0.2 micron in-line filter

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

Contact us with questions at: jeff@eastoninfusion.com or call 728-777-5546

Fax completed form and all documentation to **(561) 709-8626**

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