

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

G70.00 Myasthenia gravis w/o acute exacerbation (gMG)

G70.01 Myasthenia gravis with acute exacerbation (gMG)

ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

Insurance Information

List of Medications

Tried & Failed Therapies

Most Recent History & Physical

MG-ADL Score / MGFA Classification

Positive AChR Antibody (gMG)

MEDICATION ORDER

CYCLE: VYVGART® (efgartigimod alfa) 10 mg/kg IV in 125 mL NS over 60 minutes once weekly for 4 weeks (max dose of 1200 mg for patients weighing ≥ 120 kg)

*Flush with 20 mL NS after each infusion

Repeat cycle _____ week(s) from date of last infusion; patient to receive a total of _____ cycles

PRE-MEDICATIONS

PO

Acetaminophen: 650 mg

Cetirizine: 10 mg

Diphenhydramine: 25 mg

IV

Methylprednisolone: 125 mg

Diphenhydramine: 25 mg

OTHER: _____ PO IV

Patient to be observed for 30 minutes following each infusion. Administer per protocol. In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN