

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____
Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):
 Primary Diagnosis: _____ Myasthenia gravis without (acute) exacerbation ICD-10 Code: G70.00
 _____ Myasthenia gravis with (acute) exacerbation ICD-10 Code: G70.01
 _____ Other: _____ ICD-10 Code: _____
 Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
- Screening results for anti-acetylcholine receptor (AChR) antibodies
- Current Medication List & Immunization Records
 - Documentation of previous MG therapies trialed and outcomes (i.e. treatment failure, intolerance, contraindication, etc.)

Patient Weight: _____ lbs. Patient Height: _____ in.

VYVGART® (efgartigimod alft-fcab) J Code: J9332

4. Drug Order:

Patients Weighing less than 120 kg
 Administer Vyvgart 10 mg/kg (_____ mg) IV once weekly for four weeks (4 doses) to complete each cycle
 Provide _____ cycles with _____ weeks between each cycle

Patients Weighing 120 kg or more
 Administer Vyvgart 1,200 mg IV once weekly for four weeks (4 doses) to complete each cycle
 Provide _____ cycles with _____ weeks between each cycle

*****Note: Subsequent cycles should not be started sooner than 50 days from the start of the previous cycle.*****

Pre-Medication Orders: _____
 No Pre-Meds recommended *Adjust to patient's needs

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ **Date:** _____
 Dispense as written Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX 803.999.1754	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1760
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