INTRAMED Plus
infusion services

VYVGART®

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 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.
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 subsequent cycles beginning _____ days from the first dose of the previous 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 subsequent cycles beginning _____ days from the first dose of the previous 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** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**