Kane Hall Barry INFUSION

VYVGART (EFGARTIGIMOD ALFA-FCAB) ORDER FORM

P: 817.553.1356 | **F:** 817.553.1393

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: Myasthenia Gravis (gMG) with AChR antibody positive ICD-10 Code: ☐ G70.0 ☐ G70.1

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis and including past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy.

☐ Myasthenia Gravis Activities of Daily Living (MG-ADL) Score _____ OR Quantitative Myasthenia Gravis (QMG) Score _____

☐ Positive serologic test for anti-AChR antibodies

Others: _____

VYVGART ORDERS

☐ Patients weighing less than 120kg (264 lbs.)
Vyvgart 10mg/kg IV weekly for 4 weeks

☐ Patients weighing 120kg (264 lbs.) or greater
Vyvgart 1200mg IV weekly for 4 weeks

* If ordering a subsequent treatment cycle, indicate the start date of the last completed cycle _____ and include updated progress notes

* RN to instruct patient to hydrate pre/post infusion. RN to monitor patient for minimum of 60 min post infusion for side effects and reactions.

* Follow Kane Hall Barry Infusion Protocol for Vyvgart Infusion

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Kane Hall Barry Infusion. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____