Vyvgart <sup>®</sup> Infusion				-	Referral To: 7-438-9380
	Birmingham,AL F: 205-271-9971	Huntsville, AL F: 256-417-6408	Knoxville, TN F: 865-934-0249	Nashville, TN F: 615-645-4791	Chantilly, VA F: 703-935-2061
PREVIOUS ADMINISTRATION					
Please provide the following information: Last Infusion Date: Next Infusion Date:					
Patient Information					
Patient Name:				Weight:	
Phone Number:Allergies:					
Emergency Contact:		_		10D 10 00de	
Primary Diagnosis:					
Please attach the following: 1. Clinical progress notes and H&P to support diagnosis 2. Copy of the patient's Insurance Card 3. Positive Serologic test results if appropriate for diagnosis 4. Patient has had the appropriate meningococcal vaccines Yes No MG -ADL* score (if known): Concurrent Meds: Adverse reactions with previous MG treatments:					
Physician Information					
Prescribing Physician: Practice Phone:		Practice Name			
Email: Co-managing Physician:		Office Contact Phone/Email:			
		Medication Ord	er		
<b>Medication:</b> Vyvgart <sup>®</sup> 400mg/20mL vial injection	(efgartigimod)			# Refills	
				Refill x 1 year unless	noted otherwise.
New Start: Infuse OR	mg/kg mg intravenously over	one hour.			
Initial treatment cycle: 1 time weekly for 4 weeks, rounding to an easily measurable dose when clinically appropriate.					
Administer additional treatment cycles every weeks OR Prescriber to evaluate treatment cycle frequency after completion of initial treatment cycle. *Additional prescription will be required * Round to an easily measurable dose when clinically appropriate.					
Pre-Medication Orders: Other:					
Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.					
By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW) By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.					
Physician's NPI#	Physici	an's Address			
Prescriber's Signatur	e		Date		

Legal Notice: The prescriber is to comply with their state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the recipient named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. This prescription may be filled out at a pharmacy of the patient's choice. ©2025 ContinuumRx Services, Inc. All rights reserved.