Vyvgart® Infusion

Fax Referral To: 877-438-9380

CONTINUUMRX Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

_____ Myasthenia Gravis (MG) w/out (acute) exacerbation
_____ Myasthenia Gravis (MG) with (acute) exacerbation
_____ Other: _____

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 Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **Vyvgart® (efgartigimod)**
400mg/20mL vial injection

_____ # Refills
Refill x 1 year unless noted otherwise.

☐ ***New Start:***

Infuse _____ mg/kg
OR _____ 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# Physician's Address

_____ _____
Prescriber's Signature Date