



Checklist for Vyvgart (efgartigimod alfa-fcab) Referral

Patient Name: _____ DOB: _____ Date: _____

Referring Physician: _____ NPI: _____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- Patient demographic information
- Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- Supporting clinical notes and office visits. Two notes preferred.
 - Note should include any therapies tried/failed, and must include discussion about Vyvgart
 - Medication list and allergies
- Supporting lab reports/testing for Vyvgart treatment
 - Required: Positive serologic test for anti-AChR antibodies
 - EMG, nerve stimulation studies, positive anticholinesterase test
- Vyvgart Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible --

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 ext. 112

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterNE.com

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671



Prescribing Order: Vyvgart IV and Vyvgart Hytrulo

Date of Order: _____

Patient Name: _____ DOB: _____ M/F: _____

Diagnosis (include ICD-10 code/s): _____

NKDA Allergies: _____

Patient Weight: _____

Premedication:

- | | |
|--|--|
| <input type="checkbox"/> Acetaminophen 1000mg PO | <input type="checkbox"/> Diphenhydramine 25mg IV |
| <input type="checkbox"/> Loratadine 10mg or Cetirizine 10mg PO | <input type="checkbox"/> Solu-medrol 125mg IV |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Other: _____ |

Lab Orders:

Vyvgart IV Medication Order

- Patients < 120kg: Vyvgart 10mg/kg IV weekly x4 weeks PRN
- Patients ≥ 120kg: Vyvgart 1200mg IV weekly x4 weeks PRN
Maintenance schedule based on clinical evaluation: _____
- ✓ Dilute Vyvgart in 0.9% Sodium Chloride for a total volume of 125ml and administer via 0.22 micron filter over 1 hour

Vyvgart Hytrulo Medication Order

- Vyvgart Hytrulo 1008mg SQ weekly x4 weeks PRN
Maintenance schedule based on clinical evaluation: _____
- ✓ Inject Vyvgart Hytrulo 1008mg subcutaneously into abdomen over 30-90 seconds

Administration:

- ✓ Do not administer if patient has active signs or symptoms of infection.
- ✓ Monitor patient for 1 hour following IV administration, 30 minutes following SQ administration.
- ✓ In case of infusion/injection reaction, STOP and follow NCNE infusion reaction protocol. Notify physician.

Ordering Provider Name

NPI

Signature

Date

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