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 --

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

Call with any questions: 781-551-5812 option 4

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

Infusion Center of New England
18 Washington Street, 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:

❑ Acetaminophen 1000mg PO
❑ Loratadine 10mg or Cetirizine 10mg PO
❑ Diphenhydramine 25mg PO
❑ Diphenhydramine 25mg IV
❑ Solu-medrol 125mg IV
❑ 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 total volume of 125ml and administer via 0.22 micron filter over 1 hr

Vyvgart Hytrulo Medication Order

❑ Vyvgart Hytrulo 1008mg SQ weekly x4 weeks PRN
Maintenance schedule based on clinical evaluation: _____
❑ Vyvgart Hytrulo 1008mg SQ weekly (CIDP Only)
✓ 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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