Vyvgart® (efgartigimod alfa-fcab) Referral Form

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PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per BioHealth protocols.

LABORATORY ORDERS

CBC At each dose Every ______________________
CMP At each dose Every ______________________
CRP At each dose Every ______________________
OTHER

VYVGART THERAPY ADMINISTRATION

10 mg/kg IV weekly x 4 weeks

PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: ____
Dose: _____________________ Route: ___________________
Frequency: ____

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

Positive AchR

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Provider Name (Print) **Provider Signature** **Date**

Have a Question? (786)460-6044

Fax Referral Form To: (786)219-3917

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