

# Vyvgart (efgartigimod alfa-fcab)

Provider Order Form rev. 5/20/2022



www.aleracare.com  
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## PATIENT INFORMATION

Patient Name:		DOB:		
Patient Phone:	Patient Email:			
NKDA	Allergies:	Weight lbs/kg:	Height:	
<b>Patient Status:</b>	New to Therapy	Continuing Therapy	Therapy Change	Next Due Date (if applicable):

## PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

## DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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### ICD-10 CODE

G70.00 Myasthenia gravis without (acute) exacerbation  
G70.01 Myasthenia gravis with (acute) exacerbation  
Other: \_\_\_\_\_

### MEDICATION ORDER

**Vyvgart** (efgartigimod alfa-fcab)

Dose:  
10mg/kg IV  
1200mg IV

Frequency:  
weekly  
Duration  
4 weeks  
Other: \_\_\_\_\_

Order Expiration Date (mm/dd/yy): \_\_\_\_\_  
(If not indicated order will expire one year from date signature)

### PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO  
cetirizine (Zyrtec) 10mg PO  
loratadine (Claritin) 10mg PO  
diphenhydramine (Benadryl) 25mg 50mg / PO IV  
methylprednisolone (Solu-Medrol) 40mg IV 125mg IV  
hydrocortisone (Solu-Cortef) 100mg IV  
Other: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

### SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date

Check here if this is a stat order