

Efgartigimod alfa-fcab (Vyvgart)

Provider Order Form rev. 3/6/2026

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____
Patient Address: _____ Patient Email: _____
Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Myasthenia Gravis (with positive anti-acetylcholine receptor antibodies): _____
Other: _____ Description: _____

REQUIRED INFORMATION

Start of last Vyvgart cycle _____
Must have updated OVN showing positive response to Vyvgart and lack of disease progression & toxicity. MG-ADL score has decreased by 2 points or more from baseline.

THERAPY ADMINISTRATION & DOSING

- Administer Vyvgart 10mg/kg _____ mg intravenously in 100ml NS (*total volume 125ml*) every week for four weeks. Flush IV line with 10ml NS after infusion.
- Administer each subsequent treatment cycle _____ days from the start of the previous treatment cycle.
- Select for additional treatment cycles _____ (indicate number of cycles)
- Monitor patient for 60mins after each infusion.

For patients with weight 120kg or greater, dose is 1200mg per infusion. Infusion must be completed within 4 hours.

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

- Tylenol 500mg / 650mg PO
- Loratadine 10mg PO
- Pepcid 20mg PO / IVP
- Benadryl 25mg / 50mg PO / IVP
- Solumedrol 40mg / 125mg IVP
- Other: _____

NURSING

- Hold infusion and notify provider for abnormal vital signs or signs/symptoms of active infection or recent live vaccine.
- Monitor vital signs before, with each rate change and after infusion observation period.
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, EMG results, MRI results

Required Labs: AChR antibody, MuSK antibodies, CRP, ESR

Provider Name (*print*)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.