

Efgartigimod alfa-fcab (Vyvgart)

Provider Order Form rev. 8/23/26



PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Mobile Phone Number: _____
Weight (lbs/kg): ☐ NKDA Allergies: _____
Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

REQUIRED SUPPORTING DOCUMENTATION (Please include the following with the order to support processing & insurance approval)

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

DIAGNOSIS ICD-10 CODE (Provider must specify)

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG) ☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ Other: _____

PRIMARY MEDICATION ORDER

efgartigimod alfa-fcab (Vyvgart) administer as an intravenous infusion over one hour via a 0.2 micron in-line filter

- Dilute with 0.9% Sodium Chloride Injection prior to administration
- Monitor patients during administration and for one hour thereafter for clinical signs and symptoms of hypersensitivity reactions
- Regardless of frequency, authorization will be obtained for 6 cycles (1 full year)
- If a treatment is delayed more than 3 days, then cycle is restarted
- Order valid for 12 months unless otherwise noted: _____

☒ 10 mg/kg once weekly for 4 consecutive weeks (Max dose of 1200mg per infusion)

CYCLE FREQUENCY (select one)

- ☐ One cycle only. (Provider to submit new referral when due for following cycle.)
- ☐ Repeat cycles every 28 days from last dose for 6 total cycles for one full year
- ☐ Repeat cycle every 28 days from last dose for _____ total cycles
- ☐ Other: _____

PRE-MEDICATION

Note: pre-meds not typically indicated for Vyvgart

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ cetirizine (Zyrtec) 10mg PO
- ☐ loratadine (Claritin) 10mg PO
- ☐ famotidine (Pepcid) 20 mg IV
- ☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
- ☐ Other: _____
Dose: _____ Route: _____

NURSING

- Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

SPECIAL INSTRUCTIONS

Ordering Provider (Print) _____ Provider Signature _____ Provider NPI _____ Date _____

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zipcode: _____

ARBOR INFUSION FAX NUMBERS (Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)

☐ Arbor Infusion Fishers (317) 981-1772