

**Patient Information**

Patient Name:		DOB:	
Patient Phone:		Patient Email:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
			Last infusion date (if applicable): _____
Is the patient pregnant, planning a pregnancy or nursing:		Yes	No
		Does the patient need interpreter services:	Yes No

**Provider Information**

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

**ICD-10 CODE**

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

**Medication Order**

<b>Vyvgart</b> (efgartigimod alfa-fcab)	<b>Dose:</b> 10mg/kg IV	<b>Frequency:</b> Once weekly for 4 weeks (1 treatment cycle) every 50 days
	1200mg IV	Other: _____

**Documentation Required (Note: Send all labs, must include specific labs listed here)**

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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**Pre-Medication Order**

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

**Special Instructions (Prior therapy, treatment dates, and reasons for d/c)**

_____ Provider Name	_____ Provider Signature	_____ Date
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Order Expiration Date (mm/dd/yy): \_\_\_\_\_ (If not indicated order will expire one year from date signature) Check here if this is a stat order