

Patient Information

Patient Name: _____ DOB: _____

Patient Home Phone: _____ Patient Cell Phone: _____ Patient Email: _____

Emergency/Alternate Contact Name: _____ Emergency/Alternate Contact Phone: _____

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

G61.81 Chronic inflammatory demyelinating polyneuropathy G70.01 Myasthenia gravis with (acute) exacerbation
G70.00 Myasthenia gravis without (acute) exacerbation Other: _____

Medication Order

Vyvgart (efgartigimod alfa-fcab) **Dose:** 10mg/kg (____mg) IV **Frequency:** 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

Pre-Medication Order

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

Other: _____

Dose: _____ Route: _____ Frequency: _____

Line/Port Use Orders

RN to start/discontinue peripheral IV or access/de-access port

RN to administer 3-10 mL normal saline with heparin 100 units/mL 1-5 mL per SASH method

Do NOT administer heparin to this patient

Additional orders: _____

Adverse Reaction and Anaphylaxis Orders

Standard anaphylaxis kit (epinephrine 0.3 mg IM PRN for severe reactions x 1, may repeat once within 5-15 minutes for a maximum of 2 doses; Benadryl 50 mg PO PRN for mild-moderate reactions x 1; Benadryl 50 mg IV PRN for mild-moderate reactions x 1)

Additional orders: _____

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

Provider Name

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Provider Signature

Date

Check here if this is a stat order