Fax: 832-895-4040 Phone: 832-895-5000

Provider Name (Print)

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Vyvgart (Efgartigimod alfa-fcab)

Provider Order Form rev. 4/10/2022 ☐ New Referral ☐ Updated Order ☐ Order Renewal PATIENT INFORMATION Referral Status (check one): Patient Name: DOB: NKDA ☐ Allergies: Weight Please specify: ☐ lbs ☐ kg Height: Patient Status (check one): ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date: ICD-10 code (required): ICD-10 description: REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy. **PRESCRIPTION** NURSING THERAPY ADMINISTRATION ☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including ☐ **Efgartigimod alfa-fcab** (Vyvgart) reaction management and post-procedure observation • Dose: 10 mg/kg (patients weighing 120 kg or more, the recommended dose is 1200mg) Frequency: once weekly for four weeks (one treatment cycle) • Route: Intravenous ☐ Select for additional treatment cycles. (Indicate number of cycles) Subsequent cycles may require additional insurance authorization. Treatment cycles will be given 50 days from the start of the previous treatment cycle. ☐ Dilute with 0.9% Sodium Chloride Injection, USP prior to administration ☐ Administer as an intravenous infusion over one hour via a 0.2 micron in-line filter ☐ Monitor patients during administration and for one hour there after for clinical signs and symptoms of hypersensitivity reactions (Order will expire one year from date signed) SPECIAL INSTRUCTIONS PROVIDER INFORMATION Referral Coordinator Name: Referral Coordinator Email: Ordering Provider: Provider NPI: Referring Practice Name: Phone: Fax: Practice Address: City: State: Zip Code:

Provider Signature

Date