

VYVGART ORDER FORM

Date: _____	ICD-10 Code: _____
Patient Name: _____	Allergies: _____
Date of Birth: _____	Weight: _____ lbs OR _____ kg

Therapy Status	Provider Information
New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER

<input type="checkbox"/> Vyvgart	<input checked="" type="checkbox"/> Vyvgart 10mg/kg IV once weekly x four weeks per protocol <input checked="" type="checkbox"/> Max dose of 1200mg per infusion	Subsequent treatment cycles will require a new order.	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: <input checked="" type="checkbox"/> Positive AChR antibody test
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PRE-MEDICATIONS

<input type="checkbox"/> Acetaminophen: ___325mg ___ ^{Oral} 500mg ___650mg <input type="checkbox"/> Loratadine: 10 mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: ___25mg ___50mg <input type="checkbox"/> Famotidine: ___20mg ___40mg <input type="checkbox"/> Ibuprofen: ___200mg ___400mg ___600mg <input type="checkbox"/> Ondansetron: ___4mg ___8mg <input type="checkbox"/> Other _____	<input type="checkbox"/> Dexamethasone: ___4mg ___ ^{IV} 8mg <input type="checkbox"/> Diphenhydramine: ___25mg ___50mg <input type="checkbox"/> Famotidine: ___20mg ___40mg <input type="checkbox"/> Methylprednisolone 125mg <input type="checkbox"/> Hydrocortisone 100mg <input type="checkbox"/> Ondansetron: ___4mg ___8mg <input type="checkbox"/> Other _____
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LAB ORDERS (Please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering, and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written: _____ _____ Prescriber Name Date	Substitution Allowed: _____ _____ Prescriber Name Date
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