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Vyvgart® (efgartigimod Alfa) Order Form

Epic referral: REF115219

Patient Name____ **DOB**____________________

Address____

Phone # _________________________________ **ICD-10 Diagnosis:** G70.00 – Myasthenia Gravis

Patient Weight (include unit) _______________ Date weight taken: ______________

Rx:

Vyvgart 10 mg/kg IV in 0.9% NaCl weekly x 4 infusions

Dilute to final volume of 125 mL. If patient weighs > 120 kg, max dose of 1200 mg will be given.

Weeks in between 4-dose cycles: ☐ 4 weeks (standard) ☐Other ________

Order duration ☐ 1 year ☐ 6 months ☐Other ________

Note: it is recommended for patients to be evaluated after each cycle is completed to determine efficacy and response to therapy.

Monitor patient for 1 hour following infusion.

Other Comments: ____

Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port

Prescriber Printed Name:____

Prescriber Full Address: ____

Office Phone Number: ____________________ **Office Fax Number:** ___________________

Prescriber Signature: ___________________________________ **Date:** ________________