

Vyvgart Order

(efgartigimod alfa-fcab)



InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:** Demographics Insurance Information Current Lab Results
 H & P Relevant to Diagnosis Medication List Recent Office Notes

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

PRE-MEDICATIONS: *(usually not indicated)*

Diphenhydramine 25mg 50mg PO IV Pre-med PRN

Acetaminophen 650mg PO Pre-med PRN

VYVGART (EFGARTIGIMOD ALFA-FCAB) IV DOSING

IV Dosage in 125 mL 0.9% Sodium Chloride:

Once weekly for 4 weeks

Total dose: _____ mg (10mg/kg) Frequency: _____

Maxium Dosage 1200mg

***If new start, prescriber to evaluate frequency after initial treatment. Will need a new order.**