

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order.

Most Recent Office Visit Note, Insurance Info, Medication List,
Anti-AAcr Antibody positive test
Tried and failed: IVIG Ultomiris

PATIENT INFORMATION

PRESCRIBER INFORMATION

Patient Name: _____

Prescriber's Name: _____

DOB: _____

Signature: _____

Allergies: _____

NPI: _____ Date: _____

Weight: _____ lbs / kg Height: _____

Phone: _____ Fax: _____

Diagnosis: G70.00 _____

Office Address: _____

Other Dx/ICD10: _____

Contact Person: _____

Contact Email: _____

PRE-MEDS: NOT USUALLY INDICATED

Center will use Hypersensitivity protocol established by Infusion for Health and P.I

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

VYVGART (EFGARTIGIMOD ALFA-FCAB) IV DOSING

IV Dosage in 125 mL 0.9% Sodium Chloride:
Once weekly for 4 weeks, followed by a 4 week break, x3 cycles

Total dose: _____ **mg (10mg/kg)** **Maintenance:** _____

Maxium Dosage 1200mg

Patient can get up to 7 cycles in 1 year.
***If new start, prescriber to evaluate frequency after initial treatment. Will need a new order.**

Lab Orders: List: _____

Prior to first appointment Other Frequency: _____

Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.