Vyvgart® Referral Form

PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intake@healthcoga.com ☐ ***Initial order*** ☐ ***Reorder***

Demographics Information: Today's Date ___________________

Patient Name: ____ DOB: ___________________________

Address: ____ City: __________________ State: GA Zip: _________

Phone #: ______________________________ ☐ Cell Alternate Phone #: ___________________________ ☐ Cell

Height:_______ in/ft Weight: _______ lbs/kg Date weight recorded: _________ Last 4 of SSN: ____________

Allergies: ____ ☐ **NKDA**

Diagnosis Information: ☐ Myasthenia Gravis G70.01
☐ Other Diagnosis/ICD10Code____

Date Infusion to Begin: _________________________

Previous Infusion Reaction: ☐ YES ☐ NO

List Reactions: ________________________________

Is this a first infusion? ☐ YES ☐ NO

Date of Last Infusion: ______________________________

List of Failed Therapies: ____________________________

Assessment Questions: *Please Provide Appropriate Documentation*
MG-ADL score_________ MDFA Classification Score ______________
Diabetes? ☐ Yes ☐ No HTN? ☐ Yes ☐ No Cardiac History? ☐ Yes ☐ No Difficulty Breathing? ☐ Yes ☐ No
Requires Oxygen? ☐ Yes ☐ No Confusion /Disorientation? ☐ Yes ☐ No Neuro History? ☐ Yes ☐ No
Any Active Infections?: _________________________

Vyvgart® (efgartigimod alfa-fcab): J3032

☐ **Dose**: 10mg/kg IV over 60 minutes every week for ☐ 4 weeks or______ months (patients up to 119 kg)

☐ **Other dose**: 1200mg IV over 60 minutes every week for ☐ 4 weeks or ________ months (patients 120kg or more)

Pre-Medications: Patient to Provide and take 30 minutes prior to infusion. *Will receive 50 ml of 50ml bag of NS post- infusion*.
☐Acetaminophen 325 mg PO x1 ☐Acetaminophen 650 mg PO x1
☐ Benadryl 50mg PO X1 ☐ Benadryl 25 mg Po x1
☐ Other Pre-medication: ___________________________________

<u>Access</u>: ☐ PIV ☐ PORT ☐PICC Route: ☐ IV

Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency

PIV – NS 5ml: Qty 3

PORT – NS 10ml: Qty 3, Heparin 5mL 100units/mL x 1 per infusion.

PICC – NS 10ml:Qty 3, Heparin 5mL 10units/mL x 1 per infusion

Supplies: (please strike through if not required)

Administration Supplies (A4222) – 1 per infusion
Catheter Care Supplies (A4221) – 1 per week
Infusion Pump (E0781)
Nursing services to administer medications
Administration through an in-line 0.2-micron or less, sterile, nonpyrogenic, low-protein binding filter is required

Administer the anaphylaxis protocol for adverse reactions

Provider signature: ____

NPI # ______________________ Phone _________________________ Fax ___________________________

Office Address: __________________________________ City: ____________________ St ____Zip: _________

Printed MD Name:________________________________ Contact Name: _____________________________

☐ Demographic information ☐ Patient Ins. Card ☐ H & P ☐ Office notes ☐ Failed therapies in documentation
☐ Up to date medication list