EFGARTIGIMOD ALFA-FCAB (VYVGART™) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to: (855) 211-5843

option care health	**Patient Name:**			**Date of Birth:**	
	Address:				
	Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: Generalized myasthenia gravis (gMG) | **ICD-10 Code:** G70.01

Prescription

VYVGART™ (efgartigimod alfa-fcab) 400mg/20ml

Infuse 10 mg/kg IV over one (1) hour every week x 4 weeks for 1 treatment cycle

Max 1200mg dose for patients >120kg

Using a 50ml NS IV bag, flush IV tubing with NS 10 to 20 mL after each infusion

Infuse via a 0.2 micron in-line filter

Dispense quantity sufficient of Vyvgart™ 400mg single dose vials for each dose; withdraw calculated dose from vial and discard any unused vial contents

Ancillary Orders

Anaphylaxis Kit

➔ Required per Option Care Health policy – please complete Anaphylaxis Physician Order (FR-PC-036) provided.

Medication Orders

☐ _____

IV Flush Orders

☐ Peripheral: NS 2 to 3 mL pre-/post-use.

☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

☐ Other:

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and that I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State: **Zip:**	**Office Contact:**	

