



# VYVGART (EFGARTIGIMOD ALFA-FCAB) Infusion Orders

PHONE 515.225.2930 | FAX 515.559.2495

**Patient Information** Fax completed form, insurance information and clinical documentation to 515.559.2495.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Patient Status:**  New to Therapy  Continuing Therapy **Next Treatment Date:** \_\_\_\_\_

**Medical Information**

**Diagnosis:** Myasthenia gravis w/out acute exacerbation (ICD-10 Code: G70.00)  
 Myasthenia gravis w/acute exacerbation (ICD-10: G70.01)  
 Other: \_\_\_\_\_ (ICD-10 Code: \_\_\_\_\_ )

**gMG Classification:**  II  III  IV

**Patient weight:** \_\_\_\_\_ lbs. (required) **Allergies:** \_\_\_\_\_

**Therapy Order**

**Vyvgart**

Patients weighing <120kg (264lbs), Vyvgart 10 mg/kg IV weekly for 4 weeks  
 Patients weighing ≥120kg (264 lbs), Vyvgart 1200 mg IV weekly for 4 weeks

Cycle may be repeated less than 50 days from start of previous cycle based on clinical evaluation. Subsequent cycles may be ordered as appropriate.

Other orders: \_\_\_\_\_

**Lab Orders:** \_\_\_\_\_ **Frequency:** Every infusion Other: \_\_\_\_\_

Required labs to be drawn by:  Infusion Center  Referring Provider

**Anaphylactic reaction orders:**

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing

**Flush orders:** NS 1-20 mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

**Physician Information**

By signing this form and utilizing our services, you are authorizing Hy-Vee Health and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

**Provider Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider NPI:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Contact Person:** \_\_\_\_\_

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): \_\_\_\_\_

**Service Areas**

Des Moines, IA  West Des Moines, IA  Chicago, IL  Omaha, NE  Buffalo, NY  Dallas, TX  Phoenix, AZ  Other \_\_\_\_\_

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# COMPREHENSIVE SUPPORT FOR VYVGART THERAPY

## Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Required Documentation for Referral Processing & Insurance Approval

Include signed and completed order (MD/prescriber to complete page 1)

Include patient demographic information and insurance information

Include patient's current medication list

Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to conventional therapy

Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., pyridostigmine, immunosuppressants, corticosteroids or acetylcholinesterase inhibitors)?

Yes No

If yes, which drug(s)? \_\_\_\_\_

Has the patient required 2 or more courses of plasmapheresis/plasma exchanges and/or intravenous immune globulin for at least 12 months without symptom control?

Yes No

Myasthenia Gravis Activities of Daily Living (MG-ADL) Score: \_\_\_\_\_

Does patient have a history of abnormal neuromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation?

Yes No

Does the patient have a history of positive anticholinesterase test?

Yes No

Include labs and/or test results to support diagnosis

anti-AChR antibodies (**required**)

If ordering a subsequent treatment cycle, and patient is new to Hy-Vee Health, please indicate the start date of the last completed cycle: \_\_\_\_\_

Other medical necessity: \_\_\_\_\_

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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