

# Vyvgart® (efgartigimod alfa-fcab) Referral Form



**Preferred Clinic** (select one):

## PATIENT INFORMATION

New Referral

Updated Referral

Referral Renewal

|                         |                     |                      |
|-------------------------|---------------------|----------------------|
| DOB:                    | Patient Name:       | Patient Phone:       |
| Patient Address:        | Patient Email:      |                      |
| NKDA Allergies:         | Weight (lbs/kg):    | Height:              |
| ICD-10 Code (required): | ICD-10 Description: | Last Treatment Date: |
|                         |                     | Last 4 Digits SSN:   |

## PROVIDER INFORMATION

|                                        |                             |        |           |
|----------------------------------------|-----------------------------|--------|-----------|
| Referral Coordinator Name:             | Referral Coordinator Email: |        |           |
| Ordering Provider:                     | Provider NPI:               |        |           |
| Referring Practice Name:               | Phone:                      | Fax:   |           |
| Practice Address:                      | City:                       | State: | Zip Code: |
| Physician Preferred Method of Contact: | Email:                      | Fax:   | Phone:    |

## STANDING ORDERS

☒ Infusion to be administered per Vivo protocols.

## LABORATORY ORDERS

CBC w/ diff every \_\_\_\_\_  
CMP every \_\_\_\_\_  
OTHER \_\_\_\_\_

## PREMEDICATIONS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO  
cetirizine (Zyrtec) 10mg PO  
loratadine (Claritin) 10mg PO  
diphenhydramine (Benadryl) 25mg 50mg PO IV  
methylprednisolone (Solu-Medrol) 40mg 125mg IV  
hydrocortisone (Solu-Cortef) 100mg IV  
Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_

\*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

## VYVGART ADMINISTRATION

10 mg/kg IV weekly x 4 weeks (maximum dose is 1200mg)  
May repeat for \_\_\_\_\_ cycles  
\*\*Please provide clinical notes discussing need for recurrent cycles\*\*  
Repeat cycles every \_\_\_\_\_ days

## REQUIRED DOCUMENTATION

Patient Demographics  
Insurance Card/Information  
Progress Notes Supporting DX  
Current Medication List and H&P  
Positive AchR antibody test results  
MG-ADL Score \_\_\_\_\_ (if available)  
MGFA Classification \_\_\_\_\_ (if available)

|                       |                    |      |
|-----------------------|--------------------|------|
| Provider Name (Print) | Provider Signature | Date |
|-----------------------|--------------------|------|

Email Referrals To: [referrals@vivoinfusion.com](mailto:referrals@vivoinfusion.com) OR Fax Below

Have a Question? Call (720) 902-4111

|                           |                             |                          |                            |                         |
|---------------------------|-----------------------------|--------------------------|----------------------------|-------------------------|
| Colorado: 303-418-4679    | Massachusetts: 781-202-1629 | New Jersey: 609-955-3711 | Oklahoma: 918-770-4421     | Virginia: 804-500-5941  |
| Connecticut: 203-724-4838 | Michigan: 833-957-2188      | New York: 800-540-1852   | Pennsylvania: 215-399-9244 | Wisconsin: 414-600-5383 |
| Florida: 904-930-4211     | Minnesota: 763-290-0903     | Ohio: 216-400-0674       | Texas: 469-340-0044        |                         |

\*\*Order is valid for one year unless otherwise noted.\*\*

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