Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name: | DOB:

Allergies: | Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Generalized myasthenia gravis (gMG) anti-acetylcholine receptor (AChR) antibody positive ICD 10 Code: G70.0

☐ Other: _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes supporting primary diagnosis (must be within 1 year)

☐ Labs and Tests supporting primary diagnosis

☐ _____

List Tried & Failed Therapies, including duration of treatment:

1) 2)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Medication	Dosing	Calculated Dose	Rate of Infusion	Diluent	Schedule
☐ J3590 VYVGART (efgartigimod alfa-cab)	10 mg/kg	The staff will calculate dose based on current weight.	Infuse over 1 hour	125ml Ns	*Weekly x 4 weeks
☐ J3590 VYVGART (efgartigimod alfa-cab)	1200 mg For patient's weight greater than 120kg		Infuse over 1 hour	125ml Ns	*Weekly x 4 weeks

☐ Repeat cycle every _____ days from the first dose of previous cycle.

** Patient will be monitored for 1 hour post infusion.

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

ADDITIONAL ORDERS / INFORMATION

☐ Utilize hypersensitivity standards of care

Administration via a 0.2 micron in-line filter

PRESCRIBER INFORMATION

Prescriber name :

Office Phone: | Office Fax: | Office Email:

Prescriber Signature: | Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM
901 Medical Park Dr. Ph. 217-342-7500
Suite 201 Fax 217-342-7499
Effingham, IL 62401

INFUSION ORDERS - VYVGART™ (efgartigimod alfa-fcab)

Clinics Scan to: Physician Orders