REAL INFUSIONS
Proud Affiliate of Real Medix, LLC

VYVGART
(efgartigimod alfa-fcab)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Med List 5. Most Recent Labs 6.Tried/Failed Therapies
7. EMG Confirming MG 8. MG-ADL Assessment 9. Tried and Failed Therapies (including duration)

PRIMARY DIAGNOSIS

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG) ☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)

☐ Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Vyvgart

☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Vyvgart 10mg/kg (_____mg, not to exceed 1200mg) IV once weekly x4 doses

***Provider to determine frequency of cycles. Check ONE:

- ☐ One cycle only. (Provider to submit new referral when due for following cycle.)
- ☐ Repeat cycles every 28 days from last dose for 6 total cycles for one full year
- ☐ Repeat cycle every 28 days from last dose for_____total cycles

☐ Other_____

***Regardless of frequency, authorization will be obtained for 6 cycles (1 full year)

***If a treatment is delayed by more than 3 days, then the cycle is restarted

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)

☐ Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE