US infusions
11500 State Hwy 121 Ste 910, Frisco, TX 75035
P: 469-200-2605 F: 469-200-2606 usinfusions.org

VYVGART (EFGARTIGIMOD ALFA-FCAB) ORDER SET

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

DIAGNOSIS AND ICD-10 CODE:

Diagnosis: ☐ Myasthenia Gravis w/out acute exacerbation **(ICD-10 Code: G70.00)**
☐ Myasthenia Gravis w/acute exacerbation **(ICD-10 Code: G70.01)**
☐ Chronic inflammatory demyelinating polyneuropathy **(ICD-10 Code: G61.81)**
☐ Other: _____ **(ICD-10 Code:** _____

gMG Classification (if applicable): ☐ II ☐ III ☐ IV

Weight: _____ lbs Allergies: _____

PRESCRIPTION:

Vyvgart (IV)

☐ Patients weighing less than 120kg (264 lbs.) Vyvgart 10mg/kg IV weekly for 4 weeks
☐ Patients weighing 120kg (264 lbs.) or greater Vyvgart 1200mg IV weekly for 4 weeks

Vyvgart Hytrulo (SubQ)

☐ **gMG:** 1,008mg / 11,200 units subcutaneously once weekly for 4 weeks
☐ **CIDP:** 1,008mg / 11,200 units subcutaneously once weekly

Refills (please select):

For gMG patients (cycle may be repeated based on clinical evaluation):
☐ None ☐ Repeat for _____ cycle(s), subsequent cycle(s) to start >50 days from start of previous cycle

For CIDP patients:
☐ x 1 year ☐ Other: _____

Lab Orders: _____ **Lab Frequency:** ☐ Every infusion Other: _____

US Infusions will follow office protocol for anaphylaxis.

PROVIDER INFORMATION:

By signing this form, you authorize US Infusions and its staff to handle prior authorizations, coordinate with insurance providers, and determine the patient's preferred site of care.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

****PLEASE COMPLETE BOTH SIDES OF THIS FORM****

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REQUIRED DOCUMENTATION FOR VYVGART

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

PLEASE INCLUDE DOCUMENTATION BELOW FOR PRIOR AUTHORIZATION:

- ☐ Signed and completed order (MD/prescriber to complete page 1)
- ☐ Patient demographic information and insurance information
- ☐ 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
- ☐ labs and/or test results to support diagnosis
  - ☐ anti-AChR antibodies **(required for gMG)**
- ☐ If ordering a subsequent treatment cycle, and patient is new to Paragon, please indicate the start date of the last completed cycle _____
- ☐ Other medical necessity: _____

FAX COMPLETED FORM TO US INFUSIONS AT 469-200-2606