# Vyvgart Order Form

*Pre-filled order form for Vyvgart (efgartigimod alfa) — FcRn antagonist for myasthenia gravis*

## REFERRING PROVIDER

PROVIDER NAME | NPI | DEA (IF CONTROLLED) | SPECIALTY

PRACTICE / CLINIC NAME | OFFICE PHONE | OFFICE FAX

OFFICE CONTACT NAME | CONTACT PHONE | CONTACT EMAIL

## PATIENT INFORMATION

PATIENT LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH | SEX | PATIENT PHONE | BEST TIME TO CONTACT

ADDRESS | CITY, STATE, ZIP

## INSURANCE

PRIMARY INSURANCE | MEMBER ID | GROUP #

SECONDARY INSURANCE (IF ANY) | MEMBER ID | GROUP #

## DIAGNOSIS & CLINICAL JUSTIFICATION

PRIMARY DIAGNOSIS | ICD-10 CODE

SECONDARY DIAGNOSIS (IF APPLICABLE) | ICD-10 CODE

**Common indications for this medication:** *Generalized myasthenia gravis (anti-AChR antibody positive), Chronic inflammatory demyelinating polyneuropathy (CIDP, with Vyvgart Hytrulo)*

BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY

**PRIOR THERAPIES TRIED AND OUTCOME**

## VYVGART REFERENCE

| | |
|---|---|
| **Generic name:** | efgartigimod alfa |
| **Specialty:** | Neurology |
| **Typical infusion time:** | About 1 hour |
| **Typical schedule:** | 4 weekly infusions per cycle, cycles every 8–12 weeks |

## MEDICATION ORDER

**MEDICATION (DEFAULT: VYVGART)** | **GENERIC / ALT (EFGARTIGIMOD ALFA)** | **STRENGTH / FORMULATION**

**DOSE** | **FREQUENCY (TYPICAL: 4 WEEKLY INFUSIONS PER CYCLE, CYCLES EVERY 8&NDASH;12 WEEKS)** | **DURATION (TYPICAL: ABOUT 1 HOUR)**

**ROUTE** | **PRE-MEDICATIONS (IF ANY)** | **SPECIAL INSTRUCTIONS**

**ANTICIPATED START DATE** | **# OF DOSES AUTHORIZED** | **SUBSTITUTION ALLOWED (Y/N)** | **BIOSIMILAR ACCEPTABLE (Y/N)**

## REQUIRED LABS & MONITORING

Check all labs the prescriber requires Ascribe to verify before each infusion:

- ☐ CBC w/ differential
- ☐ CMP
- ☐ Liver function panel
- ☐ Hepatitis B/C panel
- ☐ TB screen (T-SPOT or QFT)
- ☐ Pregnancy test (urine)
- ☐ Iron studies (ferritin, TSAT)
- ☐ Vitamin levels (B12, D, folate)
- ☐ Other (specify below)

**OTHER LABS / MONITORING REQUIREMENTS**

## PRESCRIBER SIGNATURE

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Ascribe Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

**PRESCRIBER SIGNATURE** | **PRINTED NAME** | **DATE**

*Form code: ARB-ORDER-VYVGART · Submit to Ascribe Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Ascribe Infusion will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@ascribeinfusion.com*