Vyvgart® Provider Order Form

Please fax completed referral order form & all required documents to **281-295-4051**

Aqua Vivir
www.aguavivir.com

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Myasthenia Gravis without (acute) exacerbation, G70.00
☐ Myasthenia Gravis with (acute) exacerbation, G70.01
☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Vyvgart® (efgartigimod alfa)	☐ <120kg: _____mg (10 mg/kg) ☐ ≥120kg: 1200 mg	Infuse IV over 60 minutes once weekly x 4 doses *Observe patient for 1 hour after completion of infusion.

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP
☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time
☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____
☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

☐ **See Attached Medical Records**

☐ Yes ☐ No Is the patient positive for anti-acetylcholine receptor (AChR) antibodies?
☐ Yes ☐ No Does the patient have a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IV disease?
Clinical Classification: _____
☐ Yes ☐ No Does the patient have a baseline MG-Activities of Daily Living (MG-ADL) score of ≥ 5?

LAB AND TEST RESULTS (required)

☐ Anti-acetylcholine Receptor (AChR) Antibodies
☐ Baseline MG-Activities of Daily Living (MG-ADL) Evaluation Form
☐ Other: _____

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____