



Vyvgart (efgartigimod alfa-fcab) Order Form

PATIENT INFORMATIONReferral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

Allergies: _____ Weight (kg): _____ Height (cm): _____

ICD-10 Code(s) & Description (*required*): _____ (*required*) The patient's demographics, insurance, lab results, meds and recent visit notes**PRESCRIBING OFFICE**

Contact Name: _____ Contact Phone Number: _____

Ordering Provider: _____ Provider NPI: _____

Practice Name: _____ Phone: _____ Fax: _____

CLINICAL HISTORY**Please send the completed Vyvgart Path Enrollment form to Curbside Infusion.**

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug & Dose	Dates of Use	Drug & Dose	Dates of Use

THERAPY ADMINISTRATION**Vyvgart (efgartigimod alfa-fcab) IV**

Dose: 10 mg/kg (max dose: 1200 mg)

Frequency: Weekly x 4 doses

 Repeat x _____ cycles (given no sooner than 50 days from the start of the previous cycle)

Date of last infusion if known : _____ RX Expiration Date: _____

Additional Notes from Referring Office:_____
Provider Name (Print)_____
Provider Signature_____
Date