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Gastroenterology
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South Plains Infusion

VYVGART (efgartigimod alfa-fcab)

Name:_______________________ DOB:___________ M ○ F ○ PATIENT WEIGHT

Phone #1 :_____________(H/W/C) Phone #2:______________(H/W/C) ______lbs ______kg

Allergies:____

DIAGNOSIS:
☐ Myasthenia Gravis w/out acute exacerbation (ICD-10 Code: G70.00)
☐ Myasthenia Gravis w/acute exacerbation (ICD-10: G70.01)
☐ Other: _____________________________ (ICD-10: ____________)

gMG Classification: ☐ II ☐ III ☐ IV

PRE-MEDICATION ORDERS
○Tylenol 500-1000mg PO PRN ○Benadryl 25mg PO PRN
○Solu-Cortef _________ mg SIVP

VYVGART ORDER:
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)
☐ 1,008mg / 11,200 units subcutaneously once weekly for 4 weeks Cycle may be repeated based on clinical evaluation.

Refills: ☐ None ☐ Repeat for _______ cycle(s), subsequent cycle(s) to start >50 days from start of previous cycle

NOTES

ORDERING PROVIDER

Signature X______________________________ Date________________________

Provider ____________________ Phone ________________ Fax___________________

Please FAX: ○Medication Order ○Demographics ○Clinicals ○Labs ○X-Rays
to 1-806-302-1241 (must dial “1”)