Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Vyvgart Order Form

Patient Name: _____ DOB:_____

Phone:_____ Address: _____

City: _____ State:_____ Zip:_____ Email: _____

Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Myasthenia Gravis w/out acute exacerbation ICD-10: G70.00
- ☐ Myasthenia Gravis w/acute exacerbation ICD-10: G70.01
- ☐ Vyvgart Hytrulo Only - Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP) ICD-10: G61.81
- ☐ Other:_____ICD-10:_____

ORDER FOR VYVGART (efgartigimod alfa-fcab):

☐ Patients weighing less than 120kg (264 lbs) - Vyvgart 10mg/kg IV weekly for 4 weeks, repeat cycle every _____, subsequent cycles to start _____ days from previous cycle(s) x 1 year.

☐ Patients weighing 120kg (264 lbs) or greater Vyvgart 1200mg IV weekly for 4 weeks, repeat cycle every _____, subsequent cycles to start _____ days from previous cycle(s) x 1 year.

Other Directions: _____

ORDER FOR VYVGART HYTRULO (SubQ):

☐ **gMG:** 1,008mg /11,200 units efgartigimod alfa and hyaluronidase subcutaneously once weekly for 4 weeks, repeat cycle every _____, subsequent cycles to start _____ days from previous cycle(s) x 1 year.

☐ **CIDP:** 1,008mg/11,200 efgartigimod alfa and hyaluronidase subcutaneously once weekly x 1 year.

Other Directions: _____

PRE-MEDICATIONS:

- ☑ Acetaminophen 650mg PO
- ☑ Diphenhydramine 25mg IV or PO or Zyrtec 10 mg PO
- ☑ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion
LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____

Physician Signature: _____ Date:_____

Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Revised: 05/2025

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Supporting documentation to include past tried and/or failed therapies

☐ Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., pyridostigmine, immunosuppressants, corticosteroids, or acetylcholinesterase inhibitors)?

☐ Yes OR ☐ 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 OR ☐ 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 OR ☐ No

☐ Does the patient have a history of positive anticholinesterase test?

☐ Yes OR ☐ No

☐ Include labs and/or test results to support diagnosis

☐ anti-AChR antibodies (required - please attach)

☐ If ordering a subsequent treatment cycle, and patient is new to Pure, please indicate the start date of the last completed cycle _____

☐ Other medical necessity: _____

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