BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

VYVGART (EFGARTIGIMOD ALFA-FCAB)
INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:
Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____
Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

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

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Vyvgart

☐ 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

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

Other orders : _____

Lab Orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____
Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: _____ Signature: _____ Date: _____
Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____
☐ Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

BIOCARE INFUSION
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COMPREHENSIVE SUPPORT FOR VYVGART THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's current medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., pyridostigmine, immunosuppressants, corticosteroids, or acetylcholinesterase inhibitors)? ☐ Yes ☐ 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 ☐ 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 ☐ No
  - ☐ Does the patient have a history of positive anticholinesterase test? ☐ Yes ☐ N
- ☐ Include labs and/or test results to support diagnosis
  - ☐ anti-AChR antibodies **(required)**
- ☐ If ordering a subsequent treatment cycle, and patient is new to Biocare Infusion, please indicate the start date of the last completed cycle _____
- ☐ Other medical necessity: _____

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance