VYVGART®
(efgartigimod alfa-fcab)

Horizon Infusions

Location
- ☐ Camillus
- ☐ Liverpool
- ☐ New Hartford

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (315) 457-4305
Phone (315) 457-3091

1. PATIENT INFORMATION

Name:	**DOB:**
Phone:	**Other Phone:**
Email:	
Social Security #:	**Allergies:**
Gender: ☐ M ☐ F	**Weight:** ☐ Lbs ☐ Kg

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date *(if applicable)*:

2. INSURANCE INFORMATION (*required*)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		**NPI#:**
License #:	**TIN#:**	**DEA#:**
Address:		
City:		**State** **Zip**
Office Contact:		**Email:**
Office phone:		**Office fax:**

4. DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

☐ Myasthenia Gravis (_____) ☐ Other: _____

5. PRESCRIPTION INFORMATION (*requires new order every 12 months*)

☐ Administer 10mg/kg weekly x4 weeks, administered over 1 hour
OR
☐ ≥ 120kg: 1200mg weekly x4 weeks, administered over 1 hour

☐ Select for additional treatment cycles _____ (Indicate number of cycles)
- Subsequent cycles may require additional insurance authorization
- Treatment cycles will be given 50 days from the start of the previous treatment cycle

☐ Vital signs per HI Protocol
☐ Anaphylaxis & Hydration Management per HI protocol

PRE-MEDICATIONS ☐ N/A
- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
- ☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
- ☐ Diphenhydrimine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
- ☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
- ☐ Prednisone _____ mg PO
- ☐ Other _____

POST-MEDICATIONS ☐ N/A
- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
- ☐ Prednisone _____ mg PO
- ☐ Other _____

6. LABS

☐ CBC w/Diff	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CRP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CMP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ ESR	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Hepatic Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Renal Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____

☐ Quantiferon TB Gold, annually, last completed *(date)*: _____
☐ Other (*specify*):_____

7. SIGNATURE (required)

_____ _____
PHYSICIAN'S SIGNATURE **DATE**