VYVGART®
(efgartigimod alfa-fcab)

Horizon Infusions

Patient Status: ☐ NEW* ☐ CONTINUING

Next Due Date (if applicable) _____ Choose Location _

*Include recent labs and last 2 office visit notes

Name _____ DOB _____

Phone _____ Other Phone _____

Email _____ SSN _____

Allergies _____ Weight _____ ☐LBS ☐Kg Gender ☐M ☐F

INSURANCE INFORMATION (Required)

Submit copies of the front and back of primary and/or secondary insurance cards with this referral

Physician Name _____ NPI# _____

License # _____ TIN# _____ DEA# _____

Address _____

City _____ State _____ Zip _____

Office Contact _____ Email _____

Phone _____ Fax _____

DIAGNOSIS INFORMATION:

☐ **Myasthenia Gravis** _____ ☐ **Other:** _____

DOSING

☐ **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 _____

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): _____

Provider Signature _____ Date _____

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

Fax Referrals to: Kentucky (888) 977-0914 | New York (315) 457-4305 | Ohio (888) 977-0914 | Pennsylvania (724) 240-1586