

# Vyvgart (efgartigimod alfa-fcab)

Provider Order Form rev. 1/12/2026



## PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Gender: ☐ M ☐ F ☐ Other

Email Address: \_\_\_\_\_ Address: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height (in): \_\_\_\_\_

☐ NKDA Allergies: \_\_\_\_\_ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

Patient Preferred Location: \_\_\_\_\_

## DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)

☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)

☐ Other: \_\_\_\_\_

**REQUIRED DOCUMENTATION:** Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel depending on medication), signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

## PRESCRIPTION INFORMATION

**Nursing:** Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

### Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO

☐ Cetirizine (Zyrtec) 10mgPO

☐ Loratadine (Claritin) 10mgPO

☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV

☐ Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

### Lab Orders

*Required:* IGG Level, EMG Confirming MG, MG-ADL Assessment, AChR antibody positive

☐ Other: \_\_\_\_\_

**Vyvgart (efgartigimod alfa-fcab) Administration**(Select one):

☐ Vyvgart 10mg/kg (\_\_\_\_\_mg, not to exceed 1200mg) IV once weekly x4 doses

\*\*\*Provider to determine frequency of cycles.

☐ One cycle only. (Provider to submit new referral when due for following cycle.)

☐ Repeat cycle every 28 days from last dose for 6 total cycles for one full year

☐ Repeat cycle every 28 days from last dose for \_\_\_\_\_ total cycles

☐ Other: \_\_\_\_\_

\*\*\*Regardless of frequency, authorization will be obtained for 6 cycles (1 full year)

\*\*\*If a treatment is delayed by more than 3 days, then the cycle is restarted

**Post Treatment Observations:** The patient is required to stay for 30 minutes following the first administration.

☐ Refills: ☐ zero ☐ 6 months ☐ 12 months ☐ \_\_\_\_\_ (Prescription valid for one year, unless otherwise indicated)

Special Instructions: \_\_\_\_\_

## PROVIDER INFORMATION

Provider Full Name: \_\_\_\_\_ Provider NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Provider Name (Print)

Provider Signature

Date

E: [Referrals@americaninfusioncare.com](mailto:Referrals@americaninfusioncare.com)  
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Greater Houston Area F: 832.510.7824 P: 832.800.3213  
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454  
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213  
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454