Wells Infusion Centers

VYVGART ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Preferred Location: _____

Patient Information

Patient Name: DOB: Sex: ☐ M ☐ F

Address: Phone: Email:

Height (in): Weight (lb): Referral Status: ☐ New ☐ Updated ☐ Renewal

Infusion/ Injection Information

Primary ICD-10 Code: Primary ICD-10 Description:

Other ICD-10 Codes: Other ICD-10 Descriptions:

Vyvgart (Efgartigimod Alfa-fcab) Dosing Info:

☐ 10 mg/kg weekly for 4 weeks (max 1200mg)
☐ Additional _____ cycles (start dates 50 days apart)

Required Documentation:

☐ Full Patient Chart
☐ Insurance Cards (Front and Back)
☐ Clinical Notes Supporting Diagnosis
☐ List of Current Medications, Conditions, and Allergies
☐ Positive AchR antibody test
☐ MG-ADL Score _____
☐ MGFA Classification _____

Premedications:

☐ Acetaminophen _____ mg
☐ PO ☐ IV

☐ Cetirizine _____ mg ☐ PO

☐ Diphenhydramine _____ mg
☐ PO ☐ IV

☐ Hydrocortisone _____ mg ☐ IV

☐ Loratadine _____ mg ☐ PO

☐ Methylprednisolone _____ mg ☐ IV

☐ Other: _____ _____ mg
☐ PO ☐ IV

Ordering Provider Information

Practice Name: Practice Phone: Practice Fax:

Practice Address: Referral Coordinator Name:

Referral Coordinator Email: Referral Coordinator Phone:

Ordering Provider: Provider NPI: Specialty:

All Injections, Infusions, and Rescue Management for Reactions will be handled in accordance with Wells Infusion's Protocols. Orders are valid for 1 year unless stated otherwise.

_____ Provider Name

_____ Provider Signature

_____ Date

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CALL 570-4INFUSE (570-446-3873) OR EMAIL INFO@WELLSINFUSION.COM