AYSA
THERAPEUTICS INFUSION

VYVGART (EFGARTIGIMOD ALFA-FCAB) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: ☐ Myasthenia Gravis (gMG) with AChR antibody positive ICD-10 Code: _____
gMG Classification: ☐ II ☐ III ☐ IV

Patient Weight: _____ lbs. Allergies: _____

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis and including past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

☐ Myasthenia Gravis Activities of Daily Living (MG-ADL) Score _____ OR Quantitative Myasthenia Gravis (QMG) Score _____

☐ Positive serologic test for anti-AChR antibodies

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

VYVGART ORDERS

☐ 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

* If ordering a subsequent treatment cycle, indicate the start date of the last completed cycle _____ and include updated progress notes

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____
Phone: _____ Fax: _____ Contact Person: _____