VYVGART™ (efgartigimod alfa-fcab) Order/Referral Form

GAMMA THERAPEUTIC CENTER
Center for Neurological Disorders

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Greenfield, WI 53228
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www.gtinfusions.com

Patient Information	
Patient Name:	Patient DOB:

Referral Status			
☐ New Referral	☐ Restart	☐ Medication/Order Change	☐ D/C

Diagnosis and ICD 10 Code	
☐ Generalized Myasthenia Gravis (gMG)	ICD 10 Code: **G70.00**
☐ Myasthenia Gravis with Exacerbation	ICD 10 Code: **G70.01**
☐ Other Diagnosis:	ICD 10 Code:

Required Documentation	
☐ Patient demographics	☐ Clinical/Progress notes supporting primary diagnosis
☐ Copy of patient insurance card(s) – front & back	☐ Labs and tests
☐ Tried and Failed therapies	☐ Current Medication and Allergy List

Medication Orders

☐ Initial Dose: VYVGART™ – 10mg/kg body weight once weekly for 4 doses. Maximum dose: 1.2gm

☐ Maintenance Dose: VYVGART™ – 10mg/kg body weight once weekly for 4 doses. Subsequent treatment cycles may be administered based on clinical evaluation, no sooner than 50 days from the start of the previous treatment cycle.

Notes (Additional Info)

Premedication, adverse and anaphylactic reactions and post infusion will be treated per Gamma Therapeutic Center protocol.

Prescriber Information		
Prescriber Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:		Date: (Order is valid for one year)

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

Notify patient we will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.