Fax: 614-929-7199 | Phone: 614-929-3349| Email: info@infuseoneohio.com

(Efgartigimod alfa-fcab)

Vyvgart infusion orders

INFUSE ONE

Patient Name _____ DOB _____

Phone Number _____ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Myasthenia Gravis ☐ _____ Other

PRE-MEDICATIONS

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____ (other)

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ (other)

Vyvgart (Efgartigimod alfa-fcab) ORDERS

DOSAGE & FREQUENCY

☐ 10mg/kg IV once weekly for 4 weeks
(max dose 1,200 - for patients weighing 120 kg or more, the recommended dose is 1200mg)

Patient Weight
_____ lbs
_____ kg

NOTES:

ORDERING PROVIDER

Signature _____ Phone_____Fax_____

Provider _____ Date _____