



A Carelon Company

VYVGART (EFGARTIGIMOD ALFA-FCAB)

ORDER SET

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

- Diagnosis:** Myasthenia Gravis w/out acute exacerbation (ICD-10 Code: G70.00)
 Myasthenia Gravis w/acute exacerbation (ICD-10: G70.01)
 Chronic inflammatory demyelinating polyneuropathy (ICD-10: G61.81)
 Other: _____ (ICD-10: _____)

gMG Classification (if applicable): II III IV

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Vyvgart (IV)

- 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

Vyvgart Hytrulo (SubQ)

- gMG: 1,008mg / 11,200 units subcutaneously once weekly for 4 weeks
- CIDP: 1,008mg / 11,200 units subcutaneously once weekly

Refills (please select):

For gMG patients (cycle may be repeated based on clinical evaluation):

- None
- _____ refill(s), cycles to have _____ weeks between infusion cycles (4 weekly infusions = 1 treatment cycle)

For CIDP patients:

- x 1 year Other: _____

Other orders: _____

Lab Orders: _____ **Frequency:** Every infusion Other: _____

Required labs to be drawn by: Paragon Referring Provider

Home IV Biologic Ana-kit Orders (adult):

- Epinephrine: >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV (adult)
- NS 0.9% 1000mL IV bolus per protocol PRN (adult)

Home biologic injection Ana-kit (adult):

- Dispense per protocol EpiPen 0.3mg IM (2-pack)

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

Opt out of Paragon selecting site of care (if checked, please list site of care): _____

PREFERRED LOCATION

City: _____ State: _____

View our locations here:



PARAGONHEALTHCARE.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.



PHI-REF-ORD-10086-V8

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's current medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
 - Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., pyridostigmine, immunosuppressants, corticosteroids, or acetylcholinesterase inhibitors)? Yes No
If yes, which drug(s)? _____
 - Has the patient required 2 or more courses of plasmapheresis/plasma exchanges and/or intravenous immune globulin for at least 12 months without symptom control? Yes No
 - Myasthenia Gravis Activities of Daily Living (MG-ADL) Score: _____
 - Does patient have a history of abnormal neuromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation? Yes No
 - Does the patient have a history of positive anticholinesterase test? Yes No
- Include labs and/or test results to support diagnosis
 - anti-AChR antibodies **(required for gMG)**
- If ordering a subsequent treatment cycle, and patient is new to Paragon, please indicate the start date of the last completed cycle _____
- Other medical necessity: _____

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance