Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

VYVGART MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ **DOB:** _____

■ Diagnosis

☐ G70.00 Myasthenia gravis without (acute) exacerbation ☐ G70.01 Myasthenia gravis with (acute) exacerbation

■ Details Needed for Authorization

Please answer all questions and provide supporting documentation.

- Is the patient anti-acetylcholine receptor antibody positive (AChR-Ab+)? _____ If yes, please provide documentation/results.
- What Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of disease does the patient have? _____
- What is the score of the patient's Myasthenia Gravis Activities of Daily Living (MG-ADL)? _____
- What percentage of the MG-ADL score is due to non-ocular symptoms? _____
- Is the patient receiving a stable dose of ≥ 1 of acetylcholinesterase inhibitors, steroids or NSIST? _____
  If yes, which therapy/ies and for how long? _____
- Which conventional therapies has the patient had an inadequate response to? _____
- Has the patient required chronic plasmapheresis or plasma exchange therapy also? _____
- Will the patient have concomitant treatment with rituximab, eculizumab or immunoglobulins? _____
- If the patient is already on therapy with Vyvgart, have they shown clinical benefit? _____ If yes, please provide documentation.
- If the patient is already on therapy with Vyvgart, how many days have elapsed since the last treatment? _____
- If the patient is already on therapy with Vyvgart, is there evidence of unacceptable toxicity or disease progression? _____
- Please submit the patient's IgG levels.
- Please submit the patient's objective signs of neurologic weakness exams (such as QMG score). If patient is already on therapy with Vyvgart, please provide scores from before and after therapy.

■ Vyvgart (efgartigimod alfa-fcab) Medication Order

Patient's height in ft/in: _____ Patient's weight in lbs: _____

☐ First treatment cycle, 10 mg/kg weekly for 4 weeks

☐ Second treatment cycle, 10 mg/kg weekly for 4 weeks (If ordered together with 1st cycle, _____ days after the prior treatment cycle ends.)

- For patients 120kg or more, the recommended dose is 1,200mg per infusion. Please check here ☐ if you want to override this dosage
- *Note: 7 weeks was median in clinical trials.*
- *Note: The 2nd treatment cycle does not need to be selected before the 1st cycle, you can send another order afterward if needed.*

Infusion administered through 0.2 micron filtered tubing. Dose administered in 125ml of normal saline over 1 hour. Prepare and administer per manufacturer instructions. Post infusion flush with normal saline. Monitor patient throughout infusion and for 1 hour afterward.

■ Rescue Management in case of Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ Ordering Provider Authorization

Provider's Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone Line to Contact Person: _____

STANDARD DOCUMENTATION TO INCLUDE:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

Fax this order and supporting documentation to (732) 329-2322.