



Vyvgart Order

Phone: (877)-246-9104

Fax: (800) 783-9146

www.biotekrx.com

PATIENT INFORMATION (Complete or fax existing chart)				PRESCRIBER INFORMATION		
Patient Name:				Prescriber Name:		
Address:				State License:		NPI#:
City, State, Zip:				DEA:		Phone:
Phone:		2 nd Phone:		Address:		Fax:
DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			City, State, Zip:		
Weight:	Ht:	Date:		Contact Person:		Phone:
ICD-10 code: Diagnosis:						
Allergies:						
INSURANCE INFORMATION: Copy and attach the front and back of insurance and prescription card(s)						
Primary Insurance:				RX Card (PBM):		
City, State, Zip:				BIN:		PCN:
Plan#		Group#		City, State, Zip:		
Phone:				Plan#		Group#
PRESCRIPTION / ADMINISTRATION						
Medication	Dose	Calculated Dose	Rate of Infusion	Diluent	Schedule	
VYVGART™ (efgartigimod alfa-fcab)	10mg/kg	_____mg Calculated dose based on dosing weight	Infuse over 1 hour	125ml Ns	*Weekly x 4 weeks	
VYVGART™ (efgartigimod alfa-fcab)	10mg/kg	_____ 1200 mg For patient's weight greater than 120kg	Infuse over 1 hour	125ml Ns	*Weekly x 4 weeks	
VYVGART™ (efgartigimod alfa-fcab)	10mg/kg	_____mg Calculated dose based on dosing weight	Infuse over 1 hour	125ml Ns	**Weekly x _____	
*First dose to be given: _____						
** Subsequent treatment cycles to be at least 50 days from the start of the first cycle						
SIGNATURE						
x _____						

Product Substitution Permitted

Date : _____

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited.

If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Fax completed form to: (800)783-9146 - Thank you for using BioTek reMEDys®