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:	2nd Phone:		Address:	Fax:
DOB:	Gender: ☐ Male ☐ 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

× _____

Product Substitution Permitted Date: _____

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