

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX Handwritten forms will not be accepted.

PATIENT INFORMATION					
Name:					DOB:
Allergies:			Date of Referral:		
REFERRAL STATUS					
<input type="checkbox"/> New Referral		<input type="checkbox"/> Dose or Frequency Change		<input type="checkbox"/> Order Renewal	
INFUSION OFFICE PREFERENCES (Optional)					
Preferred Location* <input type="checkbox"/> Mattoon		<input type="checkbox"/> Effingham			
*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.					
Diagnosis and ICD 10 CODE					
<input type="checkbox"/> Generalized myasthenia gravis (gMG) anti-acetylcholine receptor (AChR) antibody positive			ICD 10 Code: G70.0		
<input type="checkbox"/> Other: _____			ICD 10 Code: _____		
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)					
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <small>*Patient may be required to submit a pregnancy test prior to treatment</small>			<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis (must be within 1 year) <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> _____		
List Tried & Failed Therapies, including duration of treatment:					
1) _____			2) _____		
MEDICATION ORDERS					
Dosing Wt for Calculations		Ht:	Wt (in kg):	BMI:	
Medication	Dosing	Calculated Dose	Rate of Infusion	Diluent	Schedule
<input type="checkbox"/> J3590 VYVGART (efgartigimod alfa-cab)	10 mg/kg	The staff will calculate dose based on current weight.	Infuse over 1 hour	125ml Ns	*Weekly x 4 weeks
<input type="checkbox"/> J3590 VYVGART (efgartigimod alfa-cab)		1200 mg For patient's weight greater than 120kg	Infuse over 1 hour	125ml Ns	*Weekly x 4 weeks
<input type="checkbox"/> Repeat cycle every ____ days from the first dose of previous cycle. ** Patient will be monitored for 1 hour post infusion.					
Duration		<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses			
ADDITIONAL ORDERS / INFORMATION					
<input type="checkbox"/> Utilize hypersensitivity standards of care					
Administration via a 0.2 micron in-line filter					
PRESCRIBER INFORMATION					
Prescriber name :					
Office Phone:		Office Fax:		Office Email:	
Prescriber Signature:			Date:		Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at: SBL Infusion Center
Ph. 217-258-4150
217-342-7500
Fax Completed Form and all documentation to: Fax 217-342-7499