TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

Return Completed Form To: 888.898.9113

Vyvgart Order

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: __________________

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal 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.