

VYVGART HYTRULO

(efgartigimod alfa-fcab and hyaluronidase-qvfc)



PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- EMG Confirming MG
- MG-ADL Assessment
- Tried and Failed Therapies (including duration)

PRIMARY DIAGNOSIS

- G61.81 Chronic inflammatory demyelinating polyneuritis
- G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
- G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
- Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: No recommended standard pre-meds for Vyvgart Hytrulo
- Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Myasthenia Gravis

- Vyvgart Hytrulo 1,008mg/11,200 units subQ injection once weekly x4 doses
- ***Provider to determine frequency of cycles. Check **ONE**:
- One cycle only. (Provider to submit new referral when due for following cycle.)
- Repeat cycles every 28 days from last dose for 6 total cycles for one full year
- Repeat cycle every _____ days from last dose
- Other: _____
- ***Regardless of frequency, authorization will be obtained for 6 cycles (1 full year)
- ***If a treatment is delayed by more than 3 days, then the cycle is restarted

CIDP

- Vyvgart Hytrulo 1,008mg/11,200 units subQ injection once weekly
- Other: _____
- First Dose: Y N
- Refill x12 months unless otherwise noted: _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature _____

Date _____