

VYVGART HYTRULO (EFGARTIGIMOD ALFA AND HYALURONIDASE-QVFC) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

- Myasthenia Gravis (without acute exacerbation), ICD 10: G70.00
- Myasthenia Gravis with acute exacerbation, ICD 10: G70.01
- Chronic inflammatory demyelinating polyneuropathy (CIDP), ICD 10: G61.81

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

- Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

- Acetaminophen (Tylenol) 500 mg PO
- Famotidine 20 mg IV
- Methylprednisolone (Solu-Medrol) 125 mg IVP
- Benadryl 25mg PO
- Cetirizine (Zyrtec) 10 mg PO
- Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	FREQUENCY	ROUTE
Vyvgart Hytrulo	<input type="checkbox"/> 1,008 mg efgartigimod alfa / 11,200 units hyaluronidase per 5.6 mL	<input type="checkbox"/> gMG: once weekly for 4 weeks <input type="checkbox"/> CIDP: every 4 weeks	<input type="checkbox"/> Subcutaneous Inj

Subsequent treatment cycles for gMG will require a new order.

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS