

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

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____ kg
 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	1,008 mg efgartigimod alfa / 11,200 units hyaluronidase per 5.6 mL	<input type="checkbox"/> gMG: Once weekly for 4 weeks. Subsequent treatment cycles may be ordered based on clinical evaluation. <input type="checkbox"/> CIDP: Once weekly for 1 year	Subcutaneous Inj

gMG:I authorize _____ additional cycles of treatment.

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

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:

- CT: 203.433.0621
- MA: 413.296.8482
- NC: 919.984.8698
- NY: 631.250.6020
- SC: 864.973.6279
- FL: 904.877.9270
- MD: 240.224.8607
- NH: 603.217.5371
- OH: 937.871.4594
- VA: 703.202.0499
- ME: 207.407.7272
- NJ: 201.581.4521
- PA: 610.273.5998