

# 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: once weekly for 1 year	<input type="checkbox"/> Subcutaneous Inj

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

## LABS / SPECIAL INSTRUCTIONS

**FAX NUMBERS:**  CT: 203.433.0621  MD: 240.224.8607  ME: 207.407.7272  NH: 603.217.5371  
 NJ: 201.581.4521  VA: 703.202.0499

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