Local Infusion

MYLOCALINFUSION.COM

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 (CIPD)

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	❑ Once weekly for 4 weeks	❑ Subcutaneous Inj

Subsequent treatment cycles will require a <u>new</u> order.

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

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❒ CT: 203.433.0621 ❒ ME: 207.407.7272 ❒ NH: 603.217.5371 ❒ NJ: 201.581.4521

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