

Efgartigimod alfa-hyaluronidase-qvfc (Vyvgart Hytrulo)

Provider Order Form rev. 10/03/2024

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____
Patient Address: _____ Patient Email: _____
Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Myasthenia Gravis (with positive anti-acetylcholine receptor antibodies): _____
CIDP: _____
Other: _____ Description: _____

REQUIRED INFORMATION (For Myasthenia Gravis)

Start of last Vyvgart cycle _____
Must have updated OVN showing positive response to Vyvgart and lack of disease progression & toxicity. MG-ADL score has decreased by 2 points or more from baseline.

THERAPY ADMINISTRATION & DOSING (Choose one)

For Myasthenia Gravis:

Administer Vyvgart Hytrulo 1008mg / 11200units subcutaneously over 30-90 seconds once per week for 4 weeks¹
 Monitor patient for 30mins after each injection

¹May repeat cycle no sooner than 50 days from the start of the previous treatment cycle.

For CIDP:

Administer Vyvgart Hytrulo 1008mg / 11200units subcutaneously over 30-90 seconds once per week.
 Monitor patient for 30mins after each injection

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

Other: _____

NURSING

DO NOT begin subsequent treatment cycles sooner than 50 days from the start of the previous cycle.
 Hold infusion and notify provider for abnormal vital signs or signs/symptoms of active infection or recent live vaccine.
 Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, EMG results, MRI results

Required Labs: AChR antibody, MuSK antibodies, CRP, ESR

Provider Name (print)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.