VYVGART HYTRULO

(efgartigimod alfa-fcab and hyaluronidase-qvfc)

FAX to +1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- EMG Confirming MG
- MG-ADL Assessment
- Tried and Failed Therapies (including duration)

PRIMARY DIAGNOSIS

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ Other: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Vyvgart Hytrulo
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Vyvgart Hytrulo 1,008mg/11,200 units SubQ injection once weekly x4 doses

Provider to determine frequency of cycles. Check ONE:

☐ One cycle only. (Provider to submit new referral when due for following cycle.)
☐ Repeat cycles every 28 days from last dose for 6 total cycles for one full year
☐ Repeat cycle every 28 days from last dose for _____total cycles

☐ Other: _____

Regardless of frequency, authorization will be obtained for 6 cycles (1 full year)
If a treatment is delayed by more than 3 days, then the cycle is restarted

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialists.org for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____