

Vyvgart Hytrulo

efgartigimod alfa and hyaluronidase



Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:

Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including Any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): ☐ G70.00 ☐ G70.01 ☐ G61.81 ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- ☒ Deliver patient care in accordance with Infusion for Health clinical procedures and the medication's prescribing information (PI), including management of hypersensitivity reactions

PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

- ☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO
- ☐ Other: _____
- Dose: _____ Route: _____ Frequency: _____

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ Other _____ ☐ every _____
- ☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

- ☒ Vyvgart Intravenous Infusion
- ☐ For gMG:
Dose: 10mg/kg (max dose 1200mg)
Frequency: Once weekly for 4 weeks (one treatment cycle)
Additional Treatment Cycles: ☐ _____
- *Subsequent cycles may require additional insurance authorization.
*Treatment cycles will be given 50 days from the start of the previous treatment cycle unless otherwise indicated under "Special Instructions".
(order will expire one year from date signed)
- ☒ For CIDP:
Dose: 1,008mg/11,200 units administered subcutaneously over approximately 30-90 seconds
Frequency: Once weekly
- ☒ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated, order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS:

Provider Name (Print) _____ Provider Signature _____ Date _____

- ☐ Please check this box if you DO NOT authorize Infusion for Health to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.