Efgartigimod alfa-hyaluronidase-qvfc (Vyvgart Hytrulo)

Provider Order Form rev. 01/02/2024

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):

Other: Description:

REQUIRED INFORMATION *(Choose one)*

☐ 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

☑ Administer Vyvgart Hytrulo 1008mg / 11200units subcutaneously over 30-90 seconds once per week for 4 weeks[1]

☑ Monitor patient for 30mins after each injection

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

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.