

# Efgartigimod alfa-hyaluronidase-qvfc (Vyvgart Hytrulo)

Provider Order Form rev. 3/6/2026

## 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 4weeks

Administer each subsequent treatment cycle \_\_\_\_\_ days from the start of the previous treatment cycle.

Select for additional treatment cycles \_\_\_\_\_ (indicate number of cycles)

Monitor patient for 30mins after each injection

### For CIDP:

Administer Vyvgart Hytrulo 1008mg / 11200units subcutaneously over 30-90 seconds once per week.

Monitor patient for 30mins after each injection

## PRE-MEDICATION ORDERS

Other: \_\_\_\_\_

## NURSING

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

## ADDITIONAL ORDERS

## 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