Efgartigimod alfa-hyaluronidase-qvfc (Vyvgart Hytrulo)

Provider Order Form rev. 10/28/2024

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 4weeks

☐ Select for additional treatment cycles_____ (indicate number of cycles)

☑ Monitor patient for 30mins after each injection

☑ May 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 30 mins after each injection.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every: _____

☐ CMP ☐ at each dose ☐ every: _____

☐ CRP ☐ at each dose ☐ every: _____

☐ Other: _____

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**

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.