

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/> Order Renewal	
Patient preferred clinic:			

Vyvgart® Hytrulo(efgartigimod alfa and hyaluronidase-qvfc) Standard Plan of Treatment
PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:	
Patient Name:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight: LB or KG	Gender:	Allergies:
		<input type="checkbox"/> See list	<input type="checkbox"/> NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

<input type="checkbox"/>	G70.00 - Myasthenia Gravis without acute exacerbation
<input type="checkbox"/>	G70.01 - Myasthenia Gravis with acute exacerbation
<input type="checkbox"/>	- Other: _____

REQUESTED DOCUMENTATION:
PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE: <input type="checkbox"/> Continue current order until insurance approved
5	MG-ADL Score/MGFA classification	THERAPY:	
6	Positive AChR antibody		

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive Vyvgart® if receiving antibiotics for active infectious process, antifungal therapy, fever and/or suspected infection, and/or recent or planned surgery. Initiating subsequent cycles sooner than 50 days from the start of the previous cycle has not been established.

DOSE:

☒ Vyvgart® Hytrulo 1008mg/11,200 units administered subcutaneously over 30 to 90 seconds once weekly for 4 weeks.

Monitor patient for 30 minutes post injection.

FREQUENCY:

<input type="checkbox"/>	Repeat cycle _____ weeks from date of last infusion; patient to receive _____ cycles
<input type="checkbox"/>	Other: _____

SPECIAL/LAB ORDERS:

<input type="checkbox"/>	_____
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<input checked="" type="checkbox"/>	Refills x 12 months, if frequency is defined, unless noted otherwise here:
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ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders. which can be found on our website or scan here.


PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)
DATE:

Dispense as written/Brand medically necessary	Substitution permitted	