

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 2<sup>ND</sup> AND 3<sup>RD</sup> 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 REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		<b>IF ORDER CHANGE:</b>
5	MG-ADL Score/MGFA classification		<b>Continue current order until insurance approved</b>
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:

Repeat cycle \_\_\_\_\_ weeks from date of last infusion; patient to receive \_\_\_\_\_ cycles  
 Other: \_\_\_\_\_

### SPECIAL/LAB ORDERS:

\_\_\_\_\_

Refills x 12 months, if frequency is defined, unless noted otherwise here:

### 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	



# Palmetto

## INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- Patient demographics – address, phone number, SS#, etc.**
- Insurance Information – copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

[www.PalmettoInfusion.com](http://www.PalmettoInfusion.com)