Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:	
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) CIDP 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:	☐ See list	☐ NKDA

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

☐	G61.81 - Chronic inflammatory demyelinating polyneuritis
☐	_____ - 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		**IF ORDER CHANGE:**
5			☐ **Continue current order until insurance approved**
6			

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive Vyvgart® Hytrulo if receiving antibiotics for active infectious process, antifungal therapy, fever and/or suspected infection, and/or recent or planned surgery.

DOSE:

☑ Vyvgart® Hytrulo 1,008mg/11,200 units administered subcutaneously over 30 to 90 seconds once weekly.

Monitor patient for 30 minutes post injection.

SPECIAL ORDERS:

☐ _____

_____

☑ Refills x 12 months unless noted otherwise here:

NURSING ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.	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	