



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

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) CIDP Standard Plan of Treatment

Rev. 4.29.25

PATIENT DEMOGRAPHICS:

Patient Name:	
Patient's Phone:	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:

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:
5		THERAPY:	
6			
			Continue current order until insurance approved

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:

<input type="checkbox"/>	_____
<input type="checkbox"/>	_____

<input checked="" type="checkbox"/>	Refills x 12 months unless noted otherwise here:
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NURSING ORDERS:

Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

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

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	