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) Standard Plan of Treatment

Rev. 4.30.25

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)

☐	G70.00 - Myasthenia Gravis without acute exacerbation
☐	G70.01 - Myasthenia Gravis with acute exacerbation
☐	_____- Other:_____

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	MG-ADL Score/MGFA classification
6	Positive AChR antibody

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF YES:

LAST INFUSION DATE:

NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

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.

FREQUENCY: (Select for additional treatment cycles)

☐ Patient to receive _____ cycles. Treatment cycles will be given 50 days from the start of the previous treatment cycle.

☐ OR, patient to receive _____ cycles. Repeat cycles _____ weeks from date of last injection.

☐ Other:_____

Subsequent cycles may require additional insurance authorization

SPECIAL/LAB ORDERS:

☐ _____

Monitor patient for 30 minutes post injection.

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

CARE 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	