

# Vyvgart Hytrulo

Efgartigimod alfa and hyaluronidase



Treatment Location: Dublin, OH Lancaster, OH

**PROVIDERS: Please include the following to expedite the order:**

Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing (AChR Antibody Labs); Most Recent Office Visit Note

## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ Patient Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

ICD-10 code (required):  G70.00  G70.01  G61.81 ICD Description: \_\_\_\_\_

Allergies: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height: \_\_\_\_\_

Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## NURSING

- Center will use Hypersensitivity protocol established by Infuse One Ohio
- AChR Antibody Positive Test (Attach results)

## PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

Diphenhydramine  25mg /  50mg  PO /  IV

Acetaminophen  325mg /  500mg /  650mg PO

Other: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

## THERAPY ADMINISTRATION

- Vyvgart Hytrulo Subcutaneous Injection
  - For gMG:  
Dose: 1,008mg/11,200 units administered subcutaneously over approximately 30-90 seconds  
Frequency: Once weekly for 4 weeks (one treatment cycle)  
Additional Treatment Cycles:  \_\_\_\_\_  
\*Subsequent cycles may require additional insurance authorization.  
\*Treatment cycles will be given 50 days from the start of the previous treatment cycle. (Order will expire one year from date signed.)
  - For CIDP:  
Dose: 1,008mg/11,200 units administered subcutaneously over approximately 30-90 seconds  
Frequency: Once weekly
  - Refills:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated, order will expire one year from date signed)
  - Monitor patients for 30 minutes after the completion of this injection

To ensure that a brand name product is dispensed, the prescriber must handwritten "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.

## SPECIAL INSTRUCTIONS:

Provider Name (Print) \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

- Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.