

Boca Raton
9980 Central Park Blvd
Suite 202, N
Boca Raton, FL 33428



Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)

Provider Order Form

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal
<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> Benefits Verification Only
<input type="checkbox"/> Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION
<input type="checkbox"/> efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)
<ul style="list-style-type: none">Dose: 1,008mg efgartigimod alfa and 11,200 units hyaluronidaseFrequency: once weekly for four weeks (one treatment cycle)Route: Subcutaneous over approximately 30 to 90 seconds
<input type="checkbox"/> Select for additional treatment cycles. _____ (Indicate number of cycles)
<ul style="list-style-type: none">Subsequent cycles may require additional insurance authorizationTreatment cycles will be given 50 days from the start of the previous treatment cycle.
<input type="checkbox"/> Administer subcutaneously with a winged infusion set.
<input type="checkbox"/> Monitor patients during administration and for 30 minutes after administration for clinical signs and symptoms of hypersensitivity reactions. (Order will expire one year from date signed)

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____