Connecticut
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ThrIVewell™ INFUSION
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Mission Medical

Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)

Provider Order Form

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐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

☐ **efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)**

- Dose:1,008mg efgartigimod alfa and 11,200 units hyaluronidase
- Frequency: once weekly for four weeks (one treatment cycle)
- Route: Subcutaneous over approximately 30 to 90 seconds

☐ Select for additional treatment cycles. _____ (Indicate number of cycles)

- Subsequent cycles may require additional insurance authorization
- Treatment cycles will be given 50 days from the start of the previous treatment cycle.

☐ Administer subcutaneously with a winged infusion set.
☐ 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 _____