

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



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. <tr><td></td><td><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)</td></tr>		<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)
	<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 _____