

Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830



Provider Order Form

Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)

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

☐ Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)

- Dose: 1,008mg efgartigimod

Route: Subcutaneous over approximately 30 to 90 seconds

- **Myasthenia Gravis (MG)**

_____ Weekly Infusions then,
_____ Weeks Off
_____ Repeat Cycle Refills

- **Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)**

Continuous weekly for _____ months

PRE-MEDICATION:

- ☐ _____ Tylenol 1000mg PO
☐ _____ Diphenhydramine 25mg PO
☐ _____ Cetirizine 10 mg PO
☐ _____ (other)

REQUIRED DOCUMENTATION CHECKLIST:

- ☐ _____ Patient Demographics
☐ _____ Insurance Card/Information
☐ _____ Recent Labs
☐ _____ Recent Progress

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____