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ThrIVewell™ INFUSION
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Mission Medical

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

PRE-MEDICATION:

☐ _____ Tylenol 1000mg PO

☐ _____ Diphenhydramine 25mg PO

☐ _____ Cetirizine 10 mg PO

☐ _____ (other)

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

REQUIRED DOCUMENTATION CHECKLIST:

☐ _____ Patient Demographics

☐ _____ Insurance Card/Information

☐ _____ Recent Labs

☐ _____ Recent Progress

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____