

Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081



Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

Provider Order Form

Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)

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

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:** 1,008 mg efgartigimod alfa + 11,200 units hyaluronidase
 - 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 _____