Local Infusion

MYLOCALINFUSION.COM

VYVGART HYTRULO (EFGARTIGIMOD ALFA AND HYALURONIDASE-QVFC) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Myasthenia Gravis (without acute exacerbation), ICD 10: G70.00
❑ Myasthenia Gravis with acute exacerbation, ICD 10: G70.01
❑ Chronic inflammatory demyelinating polyneuropathy (CIDP), ICD 10: G61.81

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO
❑ Benadryl 25mg PO
❑ Famotidine 20 mg IV
❑ Cetirizine (Zyrtec) 10 mg PO
❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	FREQUENCY	ROUTE
Vyvgart Hytrulo	1,008 mg efgartigimod alfa / 11,200 units hyaluronidase per 5.6 mL	❑ gMG: Once weekly for 4 weeks. Subsequent treatment cycles may be ordered based on clinical evaluation. Cycle interval: _____ ❑ CIDP: Once weekly for 1 year	Subcutaneous Inj

LABS / SPECIAL INSTRUCTIONS