LIFE SPECIALTY SOLUTIONS

VYVGART HYTRULO
(efgartigimod alfa-fcab and hyaluronidase-qvfc)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List
6. EMG Confirming MG 7. MG-ADL Assessment 8. Tried and Failed Therapies (including duration)

PRIMARY DIAGNOSIS

☐ G61.81 Chronic inflammatory demyelinating polyneuritis
☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Vyvgart Hytrulo
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Myasthenia Gravis

☐ Vyvgart Hytrulo 1,008mg/11,200 units SubQ injection once weekly x4 doses

***Provider to determine frequency of cycles. Check ONE:

☐ One cycle only. (Provider to submit new referral when due for following cycle.)
☐ Repeat cycles every 28 days from last dose for 6 total cycles for one full year
☐ Repeat cycle every 28 days from last dose for_____total cycles
☐ Other: _____

***Regardless of frequency, authorization will be obtained for 6 cycles (1 full year)
***If a treatment is delayed by more than 3 days, then the cycle is restarted

CIDP

☐ Vyvgart Hytrulo 1,008mg/11,200 units SubQ injection once weekly
☐ Other _____
FIRST DOSE?: ☐ Yes ☐ No
☑ Refill x12 months unless otherwise noted.

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____
PROVIDER SIGNATURE DATE