immersiv HEALTH

VYVGART HYTRULO® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ G61.81 Chronic inflammatory demyelinating polyneuritis (CIDP)

☐ G70.00 Myasthenia gravis w/o acute exacerbation (gMG)

☐ G70.01 Myasthenia gravis with acute exacerbation (gMG)

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information

☐ List of Medications

☐ Tried & Failed Therapies

☐ Most Recent History & Physical

☐ MG-ADL Score / MGFA classification

☐ Positive AChR Antibody (gMG)

MEDICATION ORDER

FOR CIPD

☐ Vyvgart Hytrulo® (efgartigimod alfa & hyaluronidase) 1,008 mg/11,200 units subcutaneously over 30 to 90 seconds once weekly

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

FOR gMG

☐ **CYCLE:** Vyvgart Hytrulo® (efgartigimod alfa & hyaluronidase) 1,008 mg/11,200 units subcutaneously over 30 to 90 seconds once weekly for 4 weeks

☐ Repeat cycle _____ week(S) from date of last infusion; patient to receive a total of _____ cycles

Patient to be observed for 30 minutes following each infusion.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN