

**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 CIDP

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. Administer per protocol.  
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