Vyvgart® and **Vyvgart® Hytrulo**

Provider Order Form Rev. 11/20/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: ______________________ DOB: ______________ Phone: ______________

Address: ______________________ City/ST/Zip: ______________________

Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: _______ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Myasthenia Gravis without (acute) exacerbation, G70.00

☐ Myasthenia Gravis with (acute) exacerbation, G70.01

☐ Other: ______________________, ICD10 ___________

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Vyvgart® (efgartigimod alfa)	☐ <120kg: ________mg (10 mg/kg) ☐ ≥120kg: 1200 mg	Infuse IV over 60 minutes once weekly x 4 doses ☐ May repeat above treatment cycle every ____ weeks x 1 year (no sooner than 50 days from the start of the previous treatment cycle) *Observe patient for 1 hour after completion of infusion.
Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)	☐ 5.6 mL (efgartigimod alfa 1,008 mg and hyaluronidase 11,200 units)	Inject via SC push over 30-90 seconds once weekly x 4 doses ☐ May repeat above treatment cycle every ____ weeks x 1 year (no sooner than every 50 days from the start of the previous treatment cycle) *Observe patient for 30 minutes after completion of injection.

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: ______________________

Date of last treatment: ______________ Date of next treatment: ______________

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: ______________________

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _________ ☐ CMP q _________ ☐ CRP q _________

☐ ESR q _________ ☐ LFTs q _________ ☐ Other: _____________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________ Date: ______________

Physician Name: ______________ Provider NPI: ______________ Specialty: ______________

Address: ______________________ City/ST/Zip: ______________

Contact Person: ______________ Phone #: ______________ Fax #: ______________

Email Where Follow Up Documentation Should Be Sent: ______________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ The patient is positive for anti-acetylcholine receptor (AChR) antibodies.

☐ The patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IV disease.

- Clinical Classification: _________

☐ The patient has a baseline MG-Activities of Daily Living (MG-ADL) score of ≥ 5.

- MG-ADL score: _________

LAB AND TEST RESULTS (required)

☐ Anti-acetylcholine Receptor (AChR) Antibodies

☐ Baseline MG-Activities of Daily Living (MG-ADL) Evaluation Form

☐ Other: ______________________

PRIOR FAILED THERAPIES

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________