Vyvgart Hytrulo (Efgartigimod alfa and hyaluronidase-qvfc)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs/kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:			Next Due Date:
PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
DIAGNOSIS AND ICD 10 CODE			
☐ Generalized myasthenia gravis (gMG) anti-acetylcholine receptor (AChR)antibody positive ☐Chronic inflammatory demyelinating polyneuritis (CIDP) ☐ Other: _____	ICD 10 Code: G70.00 ICD 10 Code: G61.81 ICD 10 Code: _____		
REQUIRED DOCUMENTATION/Testing			
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx	☐ anti-acetylcholine receptor (AChR) antibody result		
List Tried & Failed Therapies 1)	2)		

MEDICATION ORDERS	
gMG	☐ 1,008 mg efgartigimod alfa and 11,200 units hyaluronidase SQ over 30-90 seconds weekly x 4 weeks (1 cycle) *Refills*:* ☐ *Select for additional treatment cycles.* _____ *(may be subject to insurance authorization)* *(if not indicated order will only be utilized x1 cycle)* *Subsequent treatment cycles to be at least 50 days from the first dose of previous treatment.*
CIDP	☐ 1,008 mg efgartigimod alfa and 11,200 units hyaluronidase SQ weekly over 30-90 seconds once weekly *Refills**: ☐ X6 months ☐ X1 year ☐ Other: _____ **(if not indicated the order will expire one year from date signed)*

Provider Name (Print) **Physician Signature:** **Date:**

Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Revised 12/28/24