Provider Order Form

VYVGART HYTRULO
(EFGARTIGIMOD AND HYALURONIDASE-QVFC)

Uptiv Health

PATIENT

Full Name: DOB:

Mobile Phone: Weight: ☐ lbs ☐ kg

Allergies: ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Myasthenia Gravis (gMG) without (acute) exacerbation G70.00
☐ Myasthenia Gravis (gMG) with (acute) exacerbation G70.01
☐ Chronic inflammatory demyelinating polyneuropathy G61.81

PROVIDER

Provider Name: Provider NPI:

Practice Name: Referral Coordinator Name:

Practice Address:

Phone: Fax: Email:

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg
☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg
☐ Cetrizine (Zyrtec) 10 mg PO
☐ Other:

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Vyvgart Hytrulo (Subcutaneous Injection)	1,008 mg efgartigimod alfa / 11,200 units hyaluronidase	☐ Once weekly for 4 weeks (for gMG)
		☐ Once weekly (for CIDP)
	Additional _____ cycles	(Treatment cycles will be given 50 days from the start of the previous treatment cycle.)

☒ Subcutaneous over approximately 30 to 90 seconds
☒ Monitor patients for 30 minutes after administration for clinical signs and symptoms of hypersensitivity reactions
☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other _____ ☐ at each dose ☐ every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ Positive AchR

Provider Signature Date