HERITAGE BIOLOGICS

Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo) Patient Referral Form

Admissions Fax # 844-878-6917

Admissions Phone # 855-WE-R-RARE (855-937-7273)

Patient Demographics Information

Patient Name	SSN#	DOB

Patient Address		

Primary Phone	Cellular Phone	Work Phone

Emergency Contact Name, Relationship	Emergency Contact Phone Number

Additional Documentation Needed

- ☸ Copy of insurance cards
- ☸ Patient face sheet w/demographics
- ☸ History and Physical
- ☸ CBC w/diff, BMP, & CMP
- ☸ Recent vitals including blood pressure
- ☸ Positive serologic test for anti-AChR antibodies

Patient Insurance Information

Insurance Plan #1		Insurance Plan #2	
Subscriber Name	DOB	Subscriber Name	DOB
Policy Number	Group ID	Policy Number	Group ID

Patient Clinical Information

Gender ☐M ☐F	Height (inches)	Weight (lbs.)	Allergies (food/drug)

Statement of Medical Necessity / Primary Diagnosis

ICD10: Description of diagnosis:

Medication Information / Prescription and Orders

Medication:	**Directions:**	**Quantity/Refills**
Vyvgart Hytrulo	Infuse subcutaneously per manufacturer guidelines over 30 to 90 seconds.	Dispense: #4 doses (one month) + _____ refills ☐ Other

Dosing:

□ gMG dosing: 1,008 mg/11,200 units SubQ over 30-90 seconds once weekly x4 weeks

□ May repeat treatment cycle every _____ days from start of previous treatment cycle

□ CIDP dosing: 1,008 mg/11,200 units SubQ over 30-90 seconds once weekly

□ Other dosing: _____ mg / _____ units SubQ over 30-90 seconds every _____

*If subsequent treatment cycles only

Date of last dose: Next dose due:

Adverse Reaction Orders	**Quantity/Refills**
☸ Severe reaction (w/breathing problems): CALL 911 and administer EPHINEPHrine 0.3 mg IM.	Dispense: quantity #QS PRN refills (unless otherwise noted)

Prescriber Information

Physician Name	Office Contact

Practice Address		
NPI#	License #	Practice Phone

Physician Signature Required - Substitution Permitted	Date	Physician Signature Required - Dispense as Written	Date