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

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:

Vyvgart Hytrulo

Directions:

Infuse subcutaneously per manufacturer guidelines over 30 to 90 seconds.

Quantity/Refills

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

❁ Severe reaction (w/breathing problems): CALL 911 and administer EPHINEPHrine 0.3 mg IM.

Quantity/Refills

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