ALLIED INFUSION SERVICES

Vyvgart (efgartigimod alfa-fcab) Order
Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) Order

Phone: 713-222-2364 or 1-888-538-0060
Fax: 832-698-3961

Patient Information

Name:
DOB:
Address:
City: State:
Zip: Weight:
Phone:
Allergies:

Prescriber Information

Prescriber Name:
NPI:
Address:
City:
State: Zip:
Phone:

Diagnosis (please provide ICD-10 code in space provided):

☐ Myasthenia Gravis without (acute) exacerbation ☐ Myasthenia Gravis with (acute) exacerbation
☐ Other:

Nursing Orders: Hold infusion and notify provider for:

Signs/symptoms of illness or active infection, planned/recent surgical procedures, cough, night sweats, unintended weight loss, recent live vaccinations, active shingles. If infusion related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated.

Premedications:

☐ Tylenol 650mg PO ☐ Benadryl 25mg IV or PO ☐ Solu-Medrol IV 40mg, 125mg or ☐ mg
☐ Other: IV or PO

Order valid for one year unless otherwise indicated. IV solutions and diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability

☐ Vyvgart IV	☐ Infuse IV 10 mg/kg (Dose = ☐ mg) weekly for 4 weeks (1 cycle). Infuse over 1 hour. Mixed in 100 ml 0.9% sodium chloride. ☐ Infuse ☐ mg/kg (Dose = ☐ mg) weekly for ☐ weeks. (1 cycle). Infuse over ☐ hour(s). Mixed in 100 ml 0.9% sodium chloride. Subsequent treatment cycles must be based on clinical evaluation and no sooner than 50 days from the start of the previous treatment cycle. Use in-line, sterile, non-pyrogenic filter (pore size 0.2 micron).
☐ Vyvgart Hytrulo SQ	☐ 5.6 ml (efgartigimod alfa 1,008 mg and hyaluronidase 11,200 units) administered weekly for 4 weeks Inject via SubQ push over 30-90 seconds ☐ Other: Subsequent treatment cycles must be based on clinical evaluation and no sooner than 50 days from the start of the previous treatment cycle.

Prescriber Name (Please print):
Prescriber Signature: Date:

Please include a copy of the latest insurance information as well as all applicable clinical notes.

Email to: orders@alliedinfusion.com Fax to: 832-698-3961

By signing this form, you certify that the use of the selected treatment is medically necessary and you will be supervising the treatment of the patient. Additionally, you authorize Allied Infusion Services to act as your prior authorization designated agent when interacting with medical and prescription payors and patient assistance programs.