Fax: 832-895-4040
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adaptIV infusion

Vyvgart Hytrulo (Efgartigimod alfa-fcab)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

PLEASE CHECK FOR PREFERRED VYVGART TREATMENT. COMPLETE THE APPLICABLE PRESCRIPTION INFORMATION SECTION(S) BASED ON THIS SELECTION.

☐ **VYVGART Hytrulo** (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection

VYVGART Hytrulo is a fixed dose per injection.

DOSING

1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL (180 mg/2,000 units per mL) in a single-dose vial

DIRECTIONS

Administer subcutaneously over approximately 30 to 90 seconds once weekly for 4 weeks (4 once-weekly injections = 1 treatment cycle) with _____ weeks between treatment cycles.

REFILLS

Number of Refills (Treatment Cycles) Authorized: _____
(4 once-weekly injections = 1 treatment cycle)

☐ **VYVGART** (efgartigimod alfa-fcab) for intravenous use VYVGART is weight based. For assistance, visit vyvgarthcp.com/dosing/vyvgart.

DOSING

10 mg/kg x patient weight (kg) = dose (mg)
Strength: 400 mg/20 mL (20 mg/mL) in a 20 mL single-dose vial

CALCULATED DOSE:

Patient Weight: _____ kg
To convert from lb to kg, divide the patient's weight in lb by 2.205.
For patients weighing 120 kg or more, the dose should not exceed 1,200
☐ _____ mg (3 vials) per infusion.mg based on weight
☐ 1,200 mg for patients greater than 120 kg

DIRECTIONS

Infuse once weekly for 4 weeks
(4 once-weekly infusions = 1 treatment cycle)
with _____ weeks between infusion cycles.

REFILLS

Number of Refills (Treatment Cycles) Authorized: _____
(4 once-weekly infusions = 1 treatment cycle)

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK