

TwelveStone Health Partners

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VYVGART HYTRULO ORDER FORM

Date: _____	ICD-10 Code: _____	Therapy Status <input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____
Patient Name: _____	Allergies: _____	
Date of Birth: _____	Weight: _____ lbs OR _____ kg	

PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

MEDICATION ORDER

Vyvgart Hytrulo	<input type="checkbox"/> gMG: Infuse Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) 1,008mg/11,200 units subcutaneously over 30 to 90 seconds once weekly x four weeks (one treatment cycle). Subsequent treatment cycles may be ordered based on clinical evaluation. gMG: I authorize _____ additional cycles of treatment. Each subsequent cycle will be scheduled 50 days from the start of the previous treatment cycle, unless otherwise specified. The ordering of subsequent cycles of treatment should be based on clinical evaluation.	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: <input checked="" type="checkbox"/> Positive AChR antibody test
	<input type="checkbox"/> CIDP: Infuse Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) 1,008mg/11,200 units subcutaneously over 30 to 90 seconds weekly. Refills (CIPD): _____	

PRE-MEDICATIONS

Oral <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	IV <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work • MGADL Score and MGFA Classification
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By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written: _____	Substitution Allowed: _____
Prescriber Name _____ Date _____	Prescriber Name _____ Date _____