INTRAMED Plus
infusion services

VYVGART®/VYVGART® Hytrulo

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: ☐ Myasthenia gravis without (acute) exacerbation — ICD-10 Code: G70.00
☐ Myasthenia gravis with (acute) exacerbation — ICD-10 Code: G70.01
☐ Chronic inflammatory demyelinating polyneuritis (CIDP) — ICD-10 Code: G61.81
☐ Other:_____ — ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical notes, labs, test supporting primary diagnosis
- Screening results for anti-acetylcholine receptor (AChR) antibodies
- Current Medication List & Immunization Records
  - Documentation of previous MG therapies trialed and outcomes (i.e. treatment failure, intolerance, contraindication, etc.)

Patient
Weight: _____ lbs.
Height: _____ in.

4. Drug Order:

❑ **VYVGART®** (efgartigimod alft-fcab) JCode: J9332	❑ **VYVGART® Hytrulo** (efgartigimod alfa and hyaluronidase-qvfc) JCode: J9334
Dose: 10 mg/kg (_____ mg)* *max dose: 1200 mg for patients >120 kg Infuse intravenously over one hour once weekly for 4 weeks (4 doses) to complete one cycle.	**Dose:** 1,008 mg (5.6 mL) Infuse subcutaneously over 30-90 seconds once weekly for 4 weeks (4 doses) to complete one cycle.

Subsequent Treatment Cycle Orders:
Number of Treatment Cycles Authorized (i.e. refills):_____
Repeat subsequent cycle(s) after ___ off-weeks.
Per Prescribing Information, shortest time observed between cycles in clinical trials was four (4) weeks.
Each cycle authorized includes four (4) doses.

Pre-Medication Orders: _____
No Pre-Medications are Recommended Based on Manufacturers Guidelines

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written — Substitution permitted

Printed Physician's Name:_____ Contact Phone #: _____

FAX ALL INFORMATION **CENTRAL FAX 803.999.1754**	**INFUSION CENTER LOCATIONS** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**