Email: intake@infuseone.com | Phone: 1-800-581-0645 |
Please refer to website www.infuseone.com for location specific fax numbers

INFUSE ONE

Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

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

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per Infuse One Nursing Procedures, including reaction management and post-procedure observation **NOTE:** Infuse One Adverse Reaction Management Protocol available for review at www.infuseone.com

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

For Myasthenia Gravis

☐ efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)
- Dose: 1,008mg efgartigimod alfa and 11,200 units hyaluronidase
- Frequency: once weekly for four weeks (one treatment cycle)
- Route: Subcutaneous over approximately 30 to 90 seconds

☐ Select for additional treatment cycles. _____ (Indicate number of cycles)
- **Please note: subsequent cycles may require additional insurance authorization**
- ☐ Treatment cycles will be given 50 days from the start of the previous treatment cycle.

For Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

☐ efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytruo)
- Dose: 1,008mg efgartigimod alfa and 11,200 units hyaluronidase
- Frequency: once weekly
- Route: Subcutaneous over approximately 30 to 90 seconds

☑ Monitor patients during administration and for 30 minutes after administration for clinical signs and symptoms of hypersensitivity reactions. (Order will expire one year from date signed)

Administer subsequent treatment cycles based on clinical evaluation; the safety of initiating subsequent cycles sooner than 50 days from the start of the previous treatment cycle has not been established.

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