Vyvgart Hytrulo

(efgartigimod alfa and hyaluanidase-qvfc)

Provider Order Form *rev. 1/12/2026*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

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

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

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

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ G61.81 Chronic inflammatory demyelinating polyneuritis
☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: IGG Level, EMG Confirming MG, MG-ADL Assessment, AChR antibody positive
☐ Other: _____

Vyvgart (efgartigimod alfa-fcab and hyaluronidase-qvfc) Administration (Select one):

Myasthenia Gravis

☑ Vyvgart Hytrulo 1,008mg/11,200 units SubQ injection -once weekly x4 doses
***Provider to determine frequency of cycles. (Select one:)
☐ One cycle only. (Provider to submit new referral when due for following cycle.)
☐ Repeat cycle every 28 days from last dose for 6 total cycles for one full year
☐ Repeat cycle every 28 days from last dose for_____total cycles
☐ Other: _____
***Regardless of frequency, authorization will be obtained for 6 cycles (1 full year)
***If a treatment is delayed by more than 3 days, then the cycle is restarted

CIDP

☐ Vyvgart Hytrulo 1,008mg/11,200 units SubQ injection once weekly
☐ Other: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ **Refills:** ☐ zero ☐ 6 months ☐ 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

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

E: Referrals@americaninfusioncare.com
Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454