Vyvgart Hytrulo
REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 **PHONE:** +1(844) 650-5802

IV Solutions RX

1 PATIENT'S INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE

Address: _____ **City/State/Zip:** _____

Primary Phone: _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____

Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____

2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

Primary Insurance: _____ **Policy No:** _____ **Group:** _____

Primary RX Insurance:_____ **ID No:**_____ **RX GRP:**_____ **RX BIN:**_____ **RX PCN:**_____

DIAGNOSIS AND CLINICAL INFORMATION

Patient Clinical Information:

Diagnosis (ICD-10)**:**

☐ G70.00 Myasthenia Gravis without (acute) exacerbation ☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy
☐ G70.01 Myasthenia Gravis with (acute) exacerbation ☐ Other ICD-10:_____ Description:_____

Drug Allergies:_____ ☐ NKDA **Ht:** _____in/cm **Wt:** _____lbs/Kg

Labs *(Diagnosis of Myasthenia Gravis)*: Please fax copy of the following labs dated within 1 year of the patients referral request:
☐ **CMP** ☐ **AchR Binding / Blocking** ☐ **Musk Test** ☐ **Single-Fiber Neuropathy EMG**

Labs *(Diagnosis of CIDP)*: Please fax copy of the following labs dated within 1 year of the patients referral request:
☐ **CMP** ☐ **CSF Protein**

4 PRESCRIPTION INFORMATION

ACCESS: ☒ Subcutaneous

MEDICATION	STRENGTH	DOSE & DIRECTION	QUANTITY/ REFILLS
☐ **Vyvgart Hytrulo** *(Subcutaneous)*	**1,008 mg efgartigimod alfa** and **11,200 units hyaluronidase per 5.6 mL**	☐ **gMG dosing:** Administer 4 weekly injections (1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per week) subcutaneously over approximately 3090 seconds. Administer subsequent treatment cycles according to clinical evaluation. The safety of initiating subsequent cycles sooner than 50 days from the start of the previous treatment cycle has not been established. ☐ **CIDP dosing:** Administer weekly injections (1,008 mg efgartigimod alfa and 11,200 units	Quantity: _____ Refills: _____

PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☐ Diphenhydramine ☐ **PO** ☐ **IV**	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**
☐ Acetaminophen **(PO)**	Administer _____ mg PO 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☒ EPINEPHRINE **(vial or autoinjector)**	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes ☐ ***0.3 mg (Wt > 30 kg)*** ☐ ***0.15 mg (Wt 15-30 kg)*** ☐ ***0.1 mg (Wt 7.5-15 kg)***	Quantity: **(x1) Vial** or **(x2) Pen(s)**	Refills: **PRN**
☒ DIPHENHYDRAMINE **(50mg/mL)**	Administer via IM or slow IV push for severe anaphylactic reaction. ☐ ***50 mg (Wt > 30 kg)*** ☐ ***25 mg (Wt 15-30 kg)*** ☐ ***12.5mg (Wt 7.5-15kg)***	Quantity: **(x1) Vial(s)**	Refills: **PRN**
☒ SODIUM CHLORIDE 0.9% **(IV)**	Infuse 500 mL IV as directed for severe anaphylactic reaction.	Quantity: **Q.S**	Refills: **PRN**

NURSING/ LABS/ INFUSION SUPPLIES:

☒ **NURSING:** Nursing visits with each infusion to establish SC access, administer medication, assess and monitor patient, provide education, and complete lab draws.
☒ **INFUSION SUPPLIES:** Infusion supplies for Subcutaneous access, administration, and disposal of medication.
FLUSHING PROTOCOL: ☒ Sodium chloride 0.9%, Up to 10 mL mL before/after medication, and/or PRN to maintain patency.
☐ Heparin: ☐ 10 Units/mL ☐ 100 Units/mL, _____ as final flush and/or PRN to maintain patency

5 PRESCRIBER INFORMATION

Prescriber Name: _____ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:** _____

Address:_____ **City/ State/ Zip:** _____

Phone:_____ **Fax:** _____ **Contact Person:**_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.
I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.
CONFIDENTIALITY NOTICE: The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to **info@ivsolutionsrx.com** and destroy all copies of the original message.

Physicians signature **Date**

THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE *#welcome to our family*