PRESCRIPTION ORDER FORM

VYVGART HYTRULO

(efgartigimod alfa-fcab and hyaluronidase-qvfc)

Suite Life
Infusing health and wellness into your life.
215 Pleasant Street, 5th Floor, Fall River, MA 02721
Phone: (508) 567-5666 | Fax: (508) 567-5614

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- EMG Confirming MG
- MG-ADL Assessment
- Tried and Failed Therapies (including duration)

PRIMARY DIAGNOSIS

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

☐ CBC w/ diff & ANC: _____ ☐ LFT's at month 2 then every 3 months after ☐ Other: _____

PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

☐ Diphenhydramine 25mg PO or IVP & 50mg PO or IVP ☐ Cetrizine 10mg PO ☐ Pepcid 20mg PO or IVP
☐ Solu-Medrol 40mg IVP ☐ Solu-Cortef 125mg IVP ☐ Tylenol 650mg PO ☐ Other: _____

PRIMARY MEDICATION ORDER

☐ Vyvgart Hytrulo 1,008mg/11,200 units SubQ injection once weekly x4 doses
***Provider to determine frequency of cycles. Check **ONE**:
☐ One cycle only. (Provider to submit new referral when due for following cycle.)
☐ Repeat cycles 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

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol
(See suitelifehealth.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date