

Patient Information

Name: _____ DOB: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____
Email: _____ Weight: _____ ☐ lbs ☐ kgs
Allergies: ☐ NKDA ☐ _____

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

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

Order Information

Lab Orders (Include frequency)

Please list any labs to be drawn by the infusion clinic: _____

Pre-Medications

☒ Per infusion clinic protocol: No recommended standard pre-meds for Vyvgart Hytrulo.
☐ Provider Prescribed: _____

Primary Medication Order

Myasthenia Gravis

☐ 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.

CIDP

☐ Vyvgart Hytrulo 1,008mg/11,200 units SubQ injection
once weekly
☐ Other: _____
First Dose: ☐ Yes ☐ No
☒ Refill x12 months unless otherwise noted:

Adverse Reaction & Anaphylaxis Orders

☒ Administer acute infusion reaction and anaphylaxis medications per BluHaven Health's protocol (see BluHaven.com for policy)
☐ Other: Please fax other reaction orders if checking this box.

Provider Information

Name: _____ Office Contact: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____
Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

Provider Signature

Date