EFGARTIGIMOD ALFA-FCAB (VYVGART®) & EFGARTIGIMOD ALFA /HYALURONIDASE-QVFC (VYVGART® HYTRULO) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		
Phone:	Height: ☐ inches ☐ cm	Weight: ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

gMG Type ONLY: ☐ AChR Antibody Positive ☐ MuSK Antibody Positive ☐ Triple Seronegative ☐ LRP4 Antibody Positive

Allergies: ☐ NKDA OR (List):

Prescription

☐ **VYVGART® (efgartigimod alfa-fcab)**

- Infuse 10 mg/kg IV over one (1) hour every week x 4 weeks for 1 treatment cycle. Max 1200mg dose for patients >120kg.
- Infuse using a 0.2 micron in-line filter.
- Using a 50 mL 0.9% Sodium Chloride IV bag, flush IV tubing with 10 to 20 mL after each infusion.
- Dispense quantity sufficient of 400mg single dose vials for each dose. Round to nearest 20mg increment.
- Withdraw calculated dose from vial and discard any unused vial contents
- **Repeat cycle after _____ days from the first dose of the previous treatment cycle. Refill x 1 year.**

☐ **VYVGART® HYTRULO (efgartigimod alfa and hyaluronidase-qvfc) 1008mg/11,200 units in 5.6mL Single Dose Vial**

- Dispense 1008mg/11,200 units
- Inject **subcutaneously** over 30-90 seconds by a healthcare professional only.
- Administer using a winged 25G 12-inch tubing (maximum priming volume of 0.4mL)

☐ **VYVGART® HYTRULO (efgartigimod alfa and hyaluronidase-qvfc) 1000mg/10,000 units in 5 mL Pre-filled Syringe**

- Dispense 1000mg/10,000 units
- Self-administration by patient and/or caregiver after proper instruction in subcutaneous injection technique
- Inject **subcutaneously** over 20-30 seconds.

☐ **gMG:** Inject weekly x4 weeks for 1 cycle. Repeat the cycle after _____ days from the first dose of the previous treatment cycle. Refill x 1 year.

☐ **CIDP:** Inject weekly. Refill x 1 year.

☐ Additional Vyvgart orders: _____

Ancillary Orders

Anaphylaxis Kit

IV and HCP subcutaneous doses:

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

  Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.

Self-administered subcutaneous doses:

- Epinephrine Auto Injector 0.3 mg-2 pack kit. Inject 0.3 mg IM x 1 dose PRN anaphylaxis, repeat x 1 PRN

Pre-Medication Orders

☐ _____

IV Flush Orders

Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.

Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed. If peripheral IV, RN to insert. If port, RN to access. Refill above ancillary orders as directed x 1 year.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary and that I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

Not valid for use for patients residing in Arizona, New York, and Wisconsin