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

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

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Prescription

☐ **VYVGART® (efgartigimod alfa-fcab) 400mg in 20mL**

- Infuse 10 mg/kg IV over one (1) hour every week x 4 weeks for 1 treatment cycle. Max 1200mg dose for patients >120kg.
- Using a 50 mL 0.9% Sodium Chloride IV bag, flush IV tubing with10 to 20 mL after each infusion.
- Infuse via 0.2 micron in-line filter
- Dispense quantity sufficient of 400mg single dose vials for each dose. Round calculated dose 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**

- Infuse Subcutaneously over 30-90 seconds.
- Administer using a winged 25G 12in tubing (maximum priming volume of 0.4 mL)
- Dispense 1008mg/11,200 units

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

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

☐ Additional Vyvgart orders: _____

Ancillary Orders

Anaphylaxis Kit

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ 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) 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.

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.

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:

