

Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to **713-983-4647**.

Sincerely,
Option Care Health

VYVGART® (EFGARTIGIMOD ALFA-FCAB) & VYVGART® HYTRULO (EFGARTIGIMOD ALFA /HYALURONIDASE-QVFC) 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
- **Infuse once weekly for 4 weeks (4 once-weekly infusions = 1 treatment cycle) with _____ days between infusion cycles 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:**. Infuse once weekly for 4 weeks (4 once-weekly infusions = 1 treatment cycle) with _____ days between infusion cycles. 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:

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING**: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.

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