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

Fax completed form, insurance information, and clinical documentation to: 850-290-7456

option care health

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

Clinical Information

Primary Diagnosis Description: Generalized myasthenia gravis (gMG) **ICD-10 Code:** G70.00

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 NS IV bag, flush IV tubing with NS 10 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.

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

- Infuse Subcutaneously over 30-90 seconds every week x 4 weeks for 1 treatment cycle
- Administer using a winged 25G 12in tubing (maximum priming volume of 0.4 mL)
- Dispense 1008mg/11,200 units

Repeat cycle after _____ off-weeks. 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.
- Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

Pre-Medication Orders

☐ _____

IV Flush Orders

☐ Peripheral: NS 2 to 3 mL pre-/post-use.

☐ Implanted Port: NS 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.

☐ Other:

Lab Orders

☐ No labs ordered at this time.

☐ Other:

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed. 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:**	

