


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: _____	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: _____

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: _____

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