

Efgartigimod alfa-fcab (Vyvgart)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____

Patient Address: _____ Patient Email: _____

Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____

Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Myasthenia Gravis (with positive anti-acetylcholine receptor antibodies): _____

Other: _____ Description: _____

REQUIRED INFORMATION

Start of last Vyvgart cycle _____

Must have updated OVN showing positive response to Vyvgart and lack of disease progression & toxicity. MG-ADL score has decreased by 2 points or more from baseline.

THERAPY ADMINISTRATION & DOSING

Administer Vyvgart 10mg/kg _____ mg intravenously in 100ml NS (*total volume 125ml*) every week for four weeks.

Flush IV line with 10ml NS after infusion.

Monitor patient for 60mins after each infusion.

For patients with weight 120kg or greater, dose is 1200mg per infusion. Infusion must be completed within 4 hours.

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

Tylenol 500mg / 650mg PO

Loratadine 10mg PO

Pepcid 20mg PO / IVP

Benadryl 25mg / 50mg PO / IVP

Solumedrol 40mg / 125mg IVP

Other: _____

NURSING

DO NOT begin subsequent treatment cycles sooner than 50 days from the start of the previous cycle.

Hold infusion and notify provider for abnormal vital signs or signs/symptoms of active infection or recent live vaccine.

Monitor vital signs before, with each rate change and after infusion observation period.

Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, EMG results, MRI results

Required Labs: AChR antibody, MuSK antibodies, CRP, ESR

Provider Name (*print*)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.