COASTAL INFUSION SERVICES

1922 Highway 22 W, Suite A
Madisonville, LA 70447
Local: 985-792-9001
Toll-Free: 833-285-5500
Fax: 985-792-9004
Toll-Free: 833-235-1686

Vyvgart (efgartigimod alfa-fcab) I Order Form

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

- Copy of insurance card
- Patient demographics
- History & physical
- Labs/records: AChR antibody positive, MGFA Class, MGADL score (or document results below)

2. Patient Information

☐Male ☐Female Height: _____☐in☐cm Weight: _____☐lbs☐kg ☐NKDA Allergies: _____
Is patient up-to-date on immunizations prior to starting Vyvgart?☐Yes ☐ No, details: _____
Is this the first treatment cycle of Vyvgart?☐Yes ☐ No, dates of previous treatment cycle*: _____
Line type: ☐PIV ☐PICC ☐Port ☐Other: _____

* The safety of initiating subsequent cycles sooner than 50 days from the start of the previous treatment cycle has not been established

3. Diagnosis and Clinical Information

Primary diagnosis: _____ ICD-10: _____ Is patient anti-AChR antibody positive:☐Yes ☐No: _____
Myasthenia Gravis Foundation of America classification (Class I-V; if known): _____ Myasthenia Gravis ADL Score (if known): _____

4. Prescription Information

Intravenous Vyvgart (efgartigimod alfa-fcab) 400 mg/20 mL vial	
Dosing / Frequency	☐10 mg/kg* (_____ mg) **intravenously** once weekly for 4 weeks (**Maximum dose = 1200 mg*) ☐Other: _____
Administration	Prepare per manufacturer guidelines. Dilute calculated dose with 0.9% sodium chloride to make a total volume of 125 mL. Infuse 125 mL diluted Vyvgart solution IV over 1 hour via 0.2 micron in-line filter. After completion of infusion flush entire line with 0.9% sodium chloride and monitor patient for 1 hour
Quantity / Refills	Dispense 1 month supply (1 cycle) / Refill x _____ cycles OR ☐Other: _____ Dispense all medical supplies necessary for administration If multiple cycles ordered, pharmacy will notify prescriber when new cycle to begin

Subcutaneous Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) 1008 mg and 11,200 units/5.6 mL vial	
Dosing / Frequency	☐1008 mg/11200 units **subcutaneously** once weekly for 4 weeks ☐Other: _____
Administration	Healthcare professional to administer subcutaneously over 30 to 90 seconds Monitor patient for at least 30 minutes after injection
Quantity / Refills	Dispense 1 month supply (1 cycle) / Refill x _____ cycles OR☐Other: _____ Dispense all medical supplies necessary for administration If multiple cycles ordered, pharmacy will notify prescriber when new cycle to begin

5. Additional Orders

- If applicable (IV therapy), RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per Coastal Infusion Services Policy & Procedure.
- RN may instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.
- If a dose is missed, administer as soon as possible within 3 days; then resume on usual day of infusion

☐ Other orders: _____

6. Adverse reaction orders

☒ Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Or indicate other: _____

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
License #: _____ DEA #: _____ NPI:_____

_____ _____ _____ _____
Physician Signature (Substitution Permitted) Date **Physician Signature (Dispense as Written)** Date