

Vyvgart (efgartigimod alfa-fcab) | 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

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