ARJ Infusion SERVICES

Specialty Pharmacy and Nursing

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Intake Specialist 866-451-8804
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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 ☒ Pertinent labs and test results

2. Patient Information

☐Male ☐Female Height: _____ in/cm Weight: _____ lbs/kg 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 **Subsequent cycles no sooner than 50 days from start of previous treatment cycle*

3. Diagnosis and Clinical Information

Primary diagnosis: _____ ICD-10: _____ Confirm patient is anti-AChR antibody positive: ☐Yes

Myasthenia Gravis Foundation of America classification (Class I-V): _____ Myasthenia Gravis Activities of Daily Living Score: _____

4. Prescription Information

Medication	**Vyvgart 400 mg/20 mL vial**
Dosing / Frequency	☒ 10 mg/kg* (_____ mg) IV once weekly for 4 weeks (**Maximum dose = 1200 mg*) ☒ If a dose is missed, administer as soon as possible within 3 days; then resume on usual day of infusion
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 week supply / Refill x 3 for total of 4 infusions (1 treatment cycle)

5. Additional Orders

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure

☒ RN to instruct patient to hydrate pre/post infusion. RN to instruct patient to take acetaminophen 325-650 mg PO every 4-6 hours for 24-48 hours as needed to prevent/treat post infusion headache

☒ RN to monitor patient for minimum of 60 min post infusion. Educate on side effects, reactions, and when to contact physician

☐Other: _____

6. Adverse Reaction Orders

In the event of an infusion reaction the following orders will be followed, and the physician will be notified.

Note: For mild reactions, patient may be treated, and infusion resumed at a slower rate

☒ **STOP** infusion. Infuse D5W or NS at 20 mL/hr to keep line open, may increase to 100-250 mL/hr for hydration. If needed, may give:

☒ Diphenhydramine 50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 min **OR** 50 mg/10 mL NS IV push over 2-3 min

☒ Methylprednisolone 125 mg (**OR** _____ mg) slow IV push over 5 minutes

☒ Acetaminophen 325-650 mg (**OR** _____ mg) PO at onset of symptoms

☒ Epinephrine (1:1000) by weight for use IM or SQ in anaphylactic reaction. May repeat one time. EMS/911 will be called if used

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

License No.: _____ DEA NO.: _____ NPI: _____

_____ _____ _____ _____

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

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.