# Efgartigimod alfa-fcab (Vyvgart)

**Provider Order Form rev.** 4/2/2025

## 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.

☐ Select for additional treatment cycles_________ (indicate number of cycles)

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

☑ 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

## LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every: _______

☐ CMP ☐ at each dose ☐ every: _______

☐ CRP ☐ at each dose ☐ every: _______

☐ Other: ________________________________

## 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

☑ 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.