

Efgartigimod Alfa-Fcab (Vyvgart®) and Efgartigimod Alfa and Hyaluronidase-QVFC (Vyvgart® Hytrulo) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.
Fax completed form, insurance information and clinical documentation to 414-260-7368.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: Generalized myasthenia gravis (gMG) ICD-10 Code(s): G70.00 _____
Is this the first dose? Yes - Date of first dose _____ No - Date of next dose _____
Hepatitis B Status: Titer Date: _____ Positive Negative

Prescription

- VYVGART® (efgartigimod alfa-fcab) 400mg in 20mL**
- Infuse 10 mg/kg IV over one (1) hour every week x 4 weeks for 1 treatment cycle
 - Max 1200mg dose for patients >120kg
 - Using a 50 mL NS IV bag, flush IV tubing with NS 10 to 20 mL after each infusion
 - Infuse via 0.2 micron in-line filter
 - Dispense quantity sufficient of 400mg single dose vials for each dose. Round calculated dose to nearest 20mg increment.
- VYVGART® HYTRULO (efgartigimod alfa and hyaluronidase-qvfc) 1008mg/11,200 units in 5.6mL**
- Infuse Subcutaneously over 30-90 seconds every week x 4 weeks for 1 treatment cycle
 - Administer using a winged 25G 12in tubing (maximum priming volume of 0.4 mL)
 - Dispense 1008mg/11,200 units

Repeat cycle after _____ off-weeks. Refill x 1 year.

Additional Vyvgart orders:

Ancillary Orders

Anaphylaxis Orders

- Treat per Froedtert Home and Specialty Infusion protocol.

Pre-Medication Orders

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

- Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.
 Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab draw.

Lab Orders

- No labs ordered at this time.
 Other: _____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature _____ Date _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____



Original - Medical Records

Froedtert Home and Specialty Infusion
N86 W12999 Nightingale Way
Menomonee Falls, WI 53051
262-532-5040