EFGARTIGIMOD ALFA-FCAB (VYVGART®) AND EFGARTIGIMOD ALFA AND HYALURONIDASE-QVFC (VYVGART® HYTRULO) PRESCRIBER ORDER FORM

COMPASSUS®

Fax completed form, insurance information, and clinical documentation to: **Warren, MI t** 888-386-0886 **f** 586-263-3306

Patient Name:		Date of Birth:		
Address:				
Phone:	Height:	☐ inches ☐ cm	Weight:	☐ lbs ☐ kg

CLINICAL INFORMATION

Primary Diagnosis Description:	**ICD-10 Code:**

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.
- Withdraw calculated dose from vial and discard any unused vial contents.

☐ **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 Kit

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25mg PO or IV/IM. May repeat additionally 25mg PO or IV PRN.
- Normal saline 500 mL (> 30 kg) or 250 mL (< 30 kg) IV at KVO rate PRN anaphylaxis. Patient < 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

Pre-Medication Orders

☐ Other: _____

IV Flush Orders

☐ Peripheral: NS 2 to 3 mL pre-/post-use.

☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

☐ Other: _____

LAB ORDERS

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to initiate IV access for administration of doses in the home or alternate care setting. Access to be discontinued upon completion of infusion. 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:** _____

PRESCRIBER INFORMATION

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	