



# Vyvgart (efgartigimod alfa-fcab) Infusion Orders

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female

Diagnosis (please provide ICD10 code) \_\_\_\_\_

New Start Therapy  Continuation of Therapy Date of last dose (if applicable): \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## PRE-MEDICATION

- Acetaminophen 1000mg PO  Solu-Medrol 125mg IVP
- Diphenhydramine 25mg PO  Solu-Cortef 100mg IVP
- Ceterizine 10mg PO  Diphenhydramine 25mg IVP

## REQUIRED DOCUMENTS

- Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (please attach)

## VYVGART ORDERS

- VYVGART 10mg/kg (<120kg) once weekly x 4 weeks**  
Dilute in 125ml NS and administer intravenously over 1 hour
- VYVGART 1200MG (>120kg) once weekly x 4 weeks**  
Dilute in 125ml NS and administer intravenously over 1 hour

## Cycles may be repeated based on clinical evaluation

Refills:  None  Repeat for \_\_\_\_\_ cycles (subsequent cycles to start 50 days from day 1 of previous cycle)

### Infuse One Standing Orders:

- Provide treatment under Infuse One's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date