



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