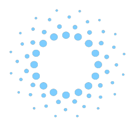
Fax: 561-516-6626 | Email: Info@infuseone.com | Phone 561-337-4055



INFUSE ONE

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

☐ Acetaminophen1000mg PO
☐ Diphenhydramine25mg PO
☐ Ceterizine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ 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