aleracare
advanced home infusion

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# Vyvgart (efgartigimod alfa-fcab)

Provider Order Form rev. 10/24/2024

## Patient Information

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

## Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

## ICD-10 CODE

◯ G61.81 Chronic inflammatory demyelinating polyneuritis

◯ G70.00 Myasthenia gravis without (acute) exacerbation

◯ G70.01 Myasthenia gravis with (acute) exacerbation

◯ Other: _____

## Medication Order

**Vyvgart** (efgartigimod alfa-fcab) **Dose:** ◯ 10mg/kg (____mg) IV ◯ 1200mg IV

**Frequency:** ◯ Once weekly for 4 weeks (1 treatment cycle) every 50 days ◯ Other: _____

## Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

## Pre-Medication Order *(given 30 min before each infusion)*

**acetaminophen** (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO

**cetirizine** (ZyrTEC) ◯ 10mg PO

**loratadine** (Claritin) ◯ 10mg PO

**diphenhydrAMINE** (Benadryl) ◯ 25mg ◯ 50mg / ◯ PO ◯ IV

**methylPREDNISolone** (SOLU-Medrol) ◯ 40mg IV ◯ 125mg IV

**hydrocortisone** (Solu-CORTEF) ◯ 100mg IV

Other: _____

Dose:_____ Route:_____ Frequency: _____

## Line/Port Use Orders

RN to start/discontinue peripheral IV or access/de-access port

◯ RN to administer 3-10 mL normal saline with heparin 100 units/mL 1-5 mL per SASH method

◯ Do NOT administer heparin to this patient

◯ Additional orders: _____

## Adverse Reaction and Anaphylaxis Orders

◯ Standard anaphylaxis kit (EPINEPHrine 0.3 mg IM PRN for severe reactions x 1, may repeat once within 5-15 minutes for a maximum of 2 doses; Benadryl 50 mg PO PRN for mild-moderate reactions x 1; Benadryl 50 mg IV PRN for mild-moderate reactions x 1)

◯ Additional orders: _____

## Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name

Provider Signature

Date

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order ◯