Conveniently Located in East Syracuse, Onondaga Hill & Auburn
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

Vyvgart (efgartigimod alfa-fcab) Non-Oncology Treatment Order Set

1. Patient Name: ____

2. DOB: _______________________________________ **Height (inches):** ____________ **Weight (lbs):** ____________

3. Diagnosis:

[ ] G70.00 Myasthenia Gravis without acute exacerbation
[ ] G70.01 Myasthenia Gravis with acute exacerbation
[ ] Other ICD-10 Code: ___________________ Diagnosis description: ____________________________

4. Pre-medications:

[ ] Acetaminophen: [ ] **1000mg PO** [ ] **500mg PO**
[ ] Diphenhydramine: [ ] **25mg PO** [ ] **50mg PO** [ ] **25mg IV** [ ] **50mg IV**
[ ] Hydrocortisone: 100mg IVP
[ ] Other Pre-medication: ____
[ ] No Pre-medications indicated

5. Drug Order:

Vyvgart (efgartigimod alfa-fcab) *Ok to substitute with generic/biosimilar*

[ ] **Patients weighing less than 120kg:** 10mg/kg IV weekly for 4 weeks.
[ ] **Patients weighing 120kg or more:** 1200mg IV weekly for 4 weeks.

[ ] Special Instructions: ____
[ ] New to Therapy
[ ] Continuing therapy: Last Dose Received ____________________ Next Dose Due ___________________

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

[ ] CBC prior to each subsequent infusion
[ ] Other: ____
[ ] No lab monitoring indicated

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.
The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. **Required Baseline Lab/Testing completed**:

[ ] CBC, date: _________ [ ] Positive Anti-Acetylcholine receptor Antibody (AChR), date: ___________
[ ] MG-ADL score: __________ [ ] MFGA classification score: ____________ [ ] IgG level, date: _________
[ ] Other: _____________________________

8. **Patient Assistance & REMS Program Enrollment**

[ ] Yes, patient has been enrolled in ________________________ program. (Provide Copy Enrollment Forms)
[ ] No, patient has not been enrolled in any programs.

7. **Physician's Name**: ____ **Phone:** __________________
Physician's Signature: ____**Date:** ________________

(This drug administration order form is valid for 12 months)