Ascension St. Vincent's Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Efgartigimod (Vyvgart) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	Weight	_____ kg	Allergies	☐ NKDA	☐ List: _____

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐ Myasthenia gravis without (acute) exacerbation ☐ Myasthenia gravis with (acute) exacerbation ☐ Other: _____	☐ G70.00 ☐ G70.01 ☐ Other: _____	☑ J9332	☑ CPT Code: _____

Labs (prior to scheduling first infusion)	Other labs:
☑ Confirm patient is anti-AChR antibody positive	☐ _____ ☐ _____

Nursing Orders	Pre-medications (not required)	
☑ Discharge patient when stable and meets protocol criteria	☐ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
Emergency/Anaphylaxis Order	☐ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☑ Follow standard orders for management of allergies and anaphylaxis reactions	☐ Dexamethasone 20 mg IV, once	☐ Other: _____
	☐ Ondansetron 4 mg IV, once	☐ Other: _____

Medication Orders

	Medication	Route	Dose	Frequency	Select Treatment Type
☑	C Efgartigimod alfa-fcab	IVPB	10 mg/kg over 60 mins (Max Dose = 1.2 g)	Once	☐ Maintenance: Every week for 4 doses ☐ Other: _____

Order Comments: Withdraw equal volume of NS to the volume of efgartigimod required for the dose for the final compounded volume 125 mL. **Infuse over 1 hour with a 0.2 micron in-line filter**. **Do NOT administer as a bolus or push.** Do NOT administer during an active infection, including localized infections. Following administration, flush entire line with NS and monitor for 1 hour.
*Pharmacy may adjust dose +/- 10% of calculated dose per Pharmacy and Therapeutics Committee approved protocol.

Infusion Center Staff Please fax infusion records or discharge summary to: **Fax Number _____**

Provider Signature		Date	
Provider Printed Name			