

ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

- | | |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> Puyallup Infusion Center - Fax: 253-697-5066 | <input type="checkbox"/> Gig Harbor Infusion Services - Fax: 253-530-8069 |
| <input type="checkbox"/> Allenmore Ambulatory Infusion Services - Fax: 253-864-4052 | <input type="checkbox"/> DHEC Infusion Center - Fax: 509-755-5845 |
| <input type="checkbox"/> Auburn Infusion Services - Fax: 253-876-8282 | <input type="checkbox"/> North Spokane Infusion Center - Fax: 509-232-2531 |

ORDERS WITH CHECK BOXES

When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Efgartigimod alfa (Vyvgart):

Patient Name: _____ Requested Date of Service: ____ / ____ / ____

Date of Birth: ____ / ____ / ____ Patient Phone Number: (____) ____ - ____ May leave message

ICD -10 Code:

Diagnosis: Myasthenia Gravis _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline Labs Required: CBC

* Patients should be up to date with all immunizations before initiating therapy. Avoid the use of live vaccines in patients undergoing efgartigimod treatment

IV Access: Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Treatment Regimen: once weekly for 4 weeks *Subsequent cycles may be administered based on clinical evaluation and no sooner than 50 days from start of the previous treatment cycle

- Efgartigimod alfa (Vyvgart) 10 mg/kg IV infusion over 1 hour for patients less than 120 kg
- Efgartigimod alfa (Vyvgart) 1200 mg IV infusion over 1 hour for patients >= 120 kg

Vital signs: Check vital signs prior to and at completion of infusion.
 Contact provider if systolic BP>180; diastolic BP>100; systolic BP<90; HR >110; temp >38C (100.4F)

If Hypersensitivity reaction (fever, chills, hypotension, rigors, itching, rash, etc.)

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: Yes No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature _____ Print Name _____ Date _____ Time _____

Another brand of drug, identical in form and content, may be dispensed unless checked **Orders expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:
 MRN #:
 CSN #:
 Age / Sex and Gender:

Pre-printed Order
MYASTHENIA GRAVIS



61-0188-3 (7/22)