Troy Infusion Center
600 W Main Street
Suite 120
Troy, OH 45373
Phone: 937-401-6620
Fax: 937-401-6629

Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
Phone: 937-401-6620
Fax: 937-401-6629

Vyvgart® (efgartigimod Alfa) Order Form

Epic referral: REF115219

Patient Name_____ **DOB**_____

Address_____

Phone # _____ **ICD-10 Diagnosis:** G70.00 – Myasthenia Gravis

Patient Weight (include unit) _____ Date weight taken: _____

Rx:

Vyvgart 10 mg/kg IV in 0.9% NaCl weekly x 4 infusions

Dilute to final volume of 125 mL

Number of 4-dose cycles: □ 1 cycle □ 6 months (3 cycles) □1 year (up to 6 cycles) □Other _____

Note: it is recommended for patients to be evaluated after each cycle is completed to determine efficacy and response to therapy.
***Subsequent cycles should not be started any sooner than 50 days from the start of the previous cycle per manufacturer safety recommendations. If multiple cycles are indicated, will treat with 4 weeks on and 4 full weeks off therapy in between each cycle.**

If patient weighs more than 120 kg, max dose of 1200 mg will be given.

Infuse with a 0.2-micron filter and flush line with normal saline after infusion to ensure entire dose given.

Monitor patient for 1 hour following infusion.

Other Comments: _____

Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port

Prescriber Printed Name:_____

Prescriber Full Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

Prescriber Signature: _____ **Date:** _____