Oregon Health & Science University Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

Efgartigimod Alfa-fcab (Vyvgart) for Myaesthenia Gravis

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Patients should be up to date with all immunizations before initiating therapy. Avoid the use of live vaccines in patients during treatment.
3. Efgartigimod Alfa-fcab may increase the risk of infection. Delay treatment in patients with an active infection until the infection is resolved. Monitor for infection during treatment, and consider withholding treatment if infection develops.
4. Do **NOT** substitute ergartigimod alfa-hyaluronidase-qvfc (for SUBQ use) and efgartigimod alfa-fcab (for IV administration); products have different dosing and are **NOT** interchangeable

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold infusion and contact provider if patient has signs or symptoms of infection.
2. Monitoring parameters depend on route selected in medications section:
    a. If IV Infusion: Monitor patient for signs and symptoms of hypersensitivity reactions during infusion and for 1 hour following completion of infusion.
    b. If Subcutaneous injection: Monitor patient for signs and symptoms of hypersensitivity reactions during infusion and for 30 minutes following completion of injection.
    Administer using 12-inch tubing, PVC winged set. Choose an injection site on abdomen a minimum of 2 to 3 inches from the naval, avoiding areas with moles or scars, or where skin is red, bruised or hard. Rotate injection sites for subsequent injections. Administer over a period of 30 to 90 seconds.
3. Monitor patient for signs and symptoms of hypersensitivity reactions during infusion and for 1 hour following completion of infusion.

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

MEDICATIONS:

- Provider to Pharmacist Communciation, Every visit, Administered once weekly x4 doses with subsequent cycles starting no sooner than 50 days from start of previous cycle (day 1, 8, 15, 22 every 50 days).

Select between IV infusion or subcutaneous injection (must choose one):

- ☐ Efgartigimod alfa-fcab (VYVGART) 10 mg/kg (maximum dose: 1200 mg) in sodium chloride 0.9%, intravenous, over 1 hour, ONCE, weekly x 4 doses with subsequent cycles of once weekly x4 doses starting no sooner than 50 days from start of previous cycle.
- ☐ Ergartigimod alfa-hyaluronidase-qvfc (VYVGART HYTRULO) subcutaneous injection 1008 mg, subcutaneous, ONCE, weekly x 4 doses with subsequent cycles of once weekly x4 doses starting no sooner than 50 days from start of previous cycle.

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Printed Name:_____ **Phone:** _____ **Fax**:_____

Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610