

PATIENT INFORMATION / REFERRAL STATUS

Referral Status: New Referral Updated Order Order Renewal **Date:** _____
Patient Name: _____ **DOB:** _____
ICD-10 Code: _____ **ICD-10 Description/Diagnosis:** _____
Allergies: NKDA **Allergies:** _____ **Weight:** _____ lbs/ kg **Height:** _____
Patient Status: New to Therapy Continuing Therapy **Last Treatment Date:** _____ **Next Due Date:** _____

PROVIDER / PRACTICE INFORMATION

Ordering Provider: _____ **Provider NPI:** _____
Referring Practice Name: _____ **Phone:** _____ **Fax:** _____
Practice Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Referral Coordinator Name: _____ **Email:** _____ **Alternative Phone Number:** _____

REFERRING PROVIDER COMMUNICATIONS

- I have reviewed the prescribing information and medication guide for Vyvgart Hytrulo (efgartigimod alfa - hyaluronidase).
- Avoid use of live vaccines during treatment and within 4 weeks of starting therapy, due to transient reduction in IgG levels during therapy. Prior to initiating therapy, complete all age-appropriate vaccinations according to current immunization guidelines.
- Evaluate for active infection. Delay administration of Efgartigimod to patients with an active infection.

NURSING PROTOCOL COMMUNICATIONS

- Provide nursing care, vital signs, monitoring according to Memorial Outpatient Procedures. Establish/maintain IV access and administer medication as ordered. Remove peripheral IV access after infusion completion if applicable. Follow infusion-related/hypersensitivity reactions management according to MHS Outpatient Adverse Reaction Protocol available for review on at mhs.net/services/pharmacy/infusion-services/outpatient-infusion.
- Discharge/Follow-up instructions according to Memorial Outpatient Procedures.

LABORATORY ORDERS

- Pregnancy, Urine for females of childbearing potential who have not undergone a hysterectomy:** Once Every Visit
- CBC with Diff:** Once Every Visit Every ____ months Once a year
- Comprehensive Metabolic Panel:** Once Every Visit Every ____ months Once a year
- CRP:** Once Every Visit Every ____ months Once a year

PRE-MEDICATION ORDERS (30-60 Minutes Prior to Therapy)

- Acetaminophen (Tylenol) 650 mg PO
- Diphenhydramine (Benadryl) 25 mg 50 mg PO **OR** Cetirizine (Zyrtec) or Loratadine (Claritin) 10 mg PO
- Dexamethasone (Decadron) 8 mg 20 mg PO
- Other: _____ Dose: _____ Route: _____ Frequency/Timing: _____

THERAPY PLAN

Medication Name: Efgartigimod alfa - hyaluronidase (Vyvgart Hytrulo)

Dose: 1,008 mg-11,200 units per 5.6 mL

Frequency:

- Once weekly x 4 weeks
- Once weekly x _____ Doses

Route: IV SQ IM

****Diluent/Volume/Concentration/Special tubing/Filters will be in accordance with the product package insert.****

- Flush with 0.9% sodium chloride at completion per protocol or medication-specific instructions

Additional Administration Instructions:

Withdraw contents from vial using a 10 mL polypropylene syringe and 18G needle. Administer using a PVC winged infusion set (25G x 12-inch) with a max priming volume of 0.4 mL. Choose an injection site on abdomen a minimum of 2-3 inches from the navel (avoiding areas with moles, scars, etc). Administer over 30 to 90 seconds. Rotate injection sites for subsequent injections. Monitor for signs/symptoms of hypersensitivity during and 30 minutes after administration.

Note to Pharmacy/Comments:

Refills: Zero for 12 months Other: _____

(if not indicated, order will expire one year from date signed)

Provider Name (Print)

Provider Signature

Date

Observe patient for infusion related and hypersensitivity reactions such as fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation, nausea, vomiting.

If reaction occurs:

- Stop infusion and assess patient.
- Maintain or establish vascular access if needed
- **Administer emergency medication(s) according to symptoms:**
 - ☒ Acetaminophen 650 mg PO once PRN headache, pain, fever >100.4F, chills or rigors.

 - ☒ Diphenhydramine 50 mg IV once PRN itching, allergies, infusion reaction, hives, pruritic and other nonspecific symptoms of allergic reaction **OR**
 - ☒ Diphenhydramine 50 mg IM once PRN itching, allergies, infusion reaction, hives, pruritic and other nonspecific symptoms of allergic reaction (if no IV access)

 - ☒ Dexamethasone 10 mg IV once PRN shortness of breath or wheezing **OR**
 - ☒ Dexamethasone 10 mg IM once PRN shortness of breath or wheezing (if no IV access)

 - ☒ Ondansetron 4 mg IV once PRN nausea, vomiting **OR**
 - ☒ Ondansetron 4 mg IM once PRN nausea, vomiting (if no IV access)
- May re-start therapy if appropriate when symptoms resolve. Resume infusion at 50% of the previous rate and increase per manufacturer's guidelines.

If a severe allergic/anaphylactic reaction occurs

- Symptoms are rapidly progressing or continuing after administration of PRN medications and/or signs and symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension)
 - ☒ Notify the Rapid Response / Rescue Alert Team / Blue Alert / 911.
 - ☒ Initiate BLS/ Cardiopulmonary resuscitation if necessary.
 - ☒ Administer Epinephrine 0.3 mg intramuscularly, every 5 MIN PRN rapidly progressing or continuing after administration of PRN medication or signs and symptoms of severe allergic/anaphylactic reaction. Administer every 5-15 minutes as needed preferably in the outer thigh.
 - ☒ Place the patient in a recumbent position, elevate lower extremities.
 - ☒ Continuously monitor vital signs (blood pressure, pulse oximetry, and heart rate).
 - ☒ Contact and notify the referring provider on the day of occurrence once patient is stabilized.
 - ☒ Document reaction in the medical record and complete an incident report once patient is stabilized.