Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Vyvgart® (efgartigimod alfa and hyaluronidase-qvfc) Infusion Order for Myasthenia Gravis (Revised 11/10/2025)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:

Allergies: (please list all allergies or attach list)

☐ NKDA

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

☐ G70.00 - Myasthenia Gravis without acute exacerbation	☐ G70.01 - Myasthenia Gravis with acute exacerbation
☐ Other:	

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion:
Complete Medication List - Include all tried and failed meds	Next infusion due date:
	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:

☑ Hold treatment and notify provider IF:
- Temperature is GREATER THAN 100oF;
- Patient complains of symptoms of acute viral or bacterial infection;
- Patient is taking an antibiotic for current infection.

Nursing Communication:

☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.

☑ Obtain vital signs PRE-treatment and POST-treatment. Obtain vital signs PRN during treatment.

☑ Monitor for any signs of reaction or side effects for 30 minutes POST-treatment

☑ To administer Vyvgart Hytrulo use a winged infusion set made of polyvinyl chloride (PVC), 25G, 12inches tubing, maximum priming volume 0.4mL.
- Prior to administration, fill the tubing of the winged infusion set by gently pressing the syringe plunger until the plunger is at 5.6mL. There should be solution at the end of the winged infusion set needle.
- Choose an injection site on the abdomen (at least 2 or 3 inches away from the navel).
- Do not inject on areas where the skin is red, bruised, tender, hard, or into areas where there are moles or scars.
- Rotate injection sites for subsequent infusions.

Pre-Medications: (Administer 30 minutes PRIOR to treament)

☐ Acetaminophen (Tylenol) 650mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg IV ONCE

☐ Loratadine (Claritin) 10mg PO ONCE

Infusion Therapy:

☑ Efgartigimod alfa-hyaluronidase qvfc (Vyvgart Hytrulo) 1,008mg-11,200unit/5.6mL SC infusion one time per week x 4 doses
- Administer over 30-90 seconds

Supportive Care Medications:

☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.

☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.

☑ Ondansetron (Zofran) 4mg PO ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:

Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: