Atrium Health Infusion Centers
Phone: 704-468-3400   Fax: 704-468-3401

Adult Vyvgart Infusion Order

Instructions to Provider: All orders with ☒ will be placed unless otherwise noted. Please fax completed order, along with referral form.

Required Lab Results: N/A

Infusion Therapy:

☐ Vyvgart (efgatigmod alfa-fcab) **10 mg/kg** IV over 1 hour

☐ Vyvgart (efgatigmod alfa-fcab) **1200 mg** IV over 1 hour (patients weighing ≥120 kg)

Frequency: Once weekly for 4 weeks   **ICD 10 code: _____**

Pre-Meds: Administer 30 minutes prior to Vyvgart   ☐ No Pre-meds Needed

☐ Acetaminophen **_____** mg PO x 1

☐ Benadryl **_____** mg PO or **_____** mg IV x 1 *(if applicable, only choose ONE)*

☐ Loratadine 10 mg PO x 1

☐ SoluMedrol **_____** mg IV x 1

Additional Orders:
_____
_____
_____

Special Instructions:

- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.
- Do not administer Vyvgart and notify ordering provider if patient has a temperature greater than 100°F, complains of symptoms of acute viral or bacterial illness, or if patient is taking antibiotics for current infection.
- Infuse using a 0.2-micron in-line filter

Infusion Monitoring:

- Obtain vital signs pre- and post-infusion and PRN throughout infusion.
- Monitor for signs of reaction for 1 hour after completion. Notify provider if patient declines to stay post-infusion.

Provider Name: _____

Provider Signature: _____

Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN: