



**St. Charles Health System**

Adult Ambulatory Infusion Order  
Efgartigimod-Hyaluronidase-qvfc  
(Vyvgart Hytrulo)

Patient Name:

Date of Birth:

*Patient Identification*

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

Treatment Start Date: \_\_\_\_\_ Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ kg Height: \_\_\_\_\_ cm

**REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety**

- 1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
- 2. Recent VISIT NOTE to support treatment (if not available in Epic)**
- 3. LAB RESULTS for any required prescreening (if not available in Epic)**
- 4. DIAGNOSIS CODE \_\_\_\_\_**
- 5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

**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. Monitor patient for signs and symptoms of hypersensitivity reactions during infusion and for 30 minutes following completion of injection.
3. 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.

**MEDICATIONS:**

Efgartigimod alfa 1008 mg/-hyaluronidase-qvfc 11,200 units (VYVGART HYTRULO) subcutaneous injection, ONCE, weekly

\_\_\_\_\_



**St. Charles Health System**

Adult Ambulatory Infusion Order  
Efgartgimod-Hyaluronidase-qvfc  
(Vyvgart Hytrulo)

Patient Name:

Date of Birth:

*Patient Identification*

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

**INFUSION MONITORING/REACTION:**

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center  
2500 NE Neff Road, Bend, OR 97701  
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

**ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION**

Signature: \_\_\_\_\_ License #: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Plan will expire 1 year after signature date at which time a new order will need to be placed**