MHS Home/Alternate Site Infusion Services
Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo) Injection Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

Patient Name:	**DOB:** _____/_____/_____	**Weight:** _____ lb/kg
Patient Phone Number: (_____) _____-_____	**Requested Date of Service:** _____/_____/_____	
Patient Allergies:		

Diagnosis: _____ **ICD – 10 Code:** _____

Baseline labs required:
CBC Date: _____/_____/_____ Result: _____

Lab Orders: _____

Additional Requirements: In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. **** Emergency phone number for provider _____ (required) ****

Provider Order for Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo) Injection

ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Medication:
Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo) 1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL (180 mg/2,000 units per mL) SUBQ over 30-90 seconds.

Frequency: ☐ Once weekly for 4 weeks ☐ Other: _____

*Subsequent cycles may be administered based on clinical evaluation and no sooner than 50 days from the start of the previous treatment cycle.

Skilled Nurse Interventions:

- Admit *(first visit)* patient to services for home/alternate site injection therapy of Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo).
- Complete Skilled Nurse visit with each injection for ongoing home/alternate site injection therapy of Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)
- Obtain vital signs (TPR & B/P) at baseline, completion of injection, and 30 minutes post-injection.
- Obtain patient weight at each visit.
- Draw labs as ordered.
- Inject Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo) as prescribed.
- If vital signs are stable 30 minutes after injection, Skilled Nurse will complete visit.

CONTINUED ON NEXT PAGE

If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.):
The Skilled Nurse will:

- Administer emergency medications as prescribed (*below*).
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor

Emergency Medications: To be administered by skilled nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access is available. Max dose = 50 mg.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access is available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO2>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ☐ Yes ☐ No (if yes, please send DOCUMENTATION of consent with order)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

Provider Signature: _____ **Printed Name:** _____ **Date:** _____

NPI: _____ Orders expire in 12 months unless otherwise specified: _____

Provider/Clinic Information:	**Return completed orders to:**
Address: _____	MultiCare Home/Alternate Site Infusion Services 253-459-6650 (*phone*) / 253-864-2785 (*fax*)
Phone #: _____ Fax#: _____	

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:	Pre-printed order – Page 2 of 2
Name:	Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)
MRN:	MultiCare Revised 09/24
DOB:	