

## VYVGART REFERRAL FORM

PATIENT DEMOGRAPHICS:				
PATIENT NAME:		PATIENT'S CONTACT #:		
DATE OF REFERRAL:		ADDRESS:		
DATE OF BIRTH:		CITY, STATE, ZIP:		
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:				
HEIGHT: _____ FEET _____ INCHES	GENDER: FEMALE MALE			
WEIGHT: _____ LB or _____ KG	ALLERGIES: SEE LIST NKDA			
PRIMARY DIAGNOSIS:				
G70.00 - Myasthenia gravis without (acute) exacerbation		G70.01 - Myasthenia gravis with (acute) exacerbation		
Other _____				
REQUIRED DOCUMENTATION: <u>Please provide a copy of the following documents.</u>				
<input checked="" type="checkbox"/> 1. INSURANCE CARD (Front & Back) <input checked="" type="checkbox"/> 2. PATIENT DEMOGRAPHICS <input checked="" type="checkbox"/> 3. MOST RECENT LABS <input checked="" type="checkbox"/> 4. MEDICATION LIST <input checked="" type="checkbox"/> 5. H & P <input checked="" type="checkbox"/> 6. EMG CONFIRMING MG <input checked="" type="checkbox"/> 7. MG-ADL ASSESSMENT <input checked="" type="checkbox"/> 8. TRIED THERAPIES (INCLUDE DURATION)				
PRIMARY MEDICATION ORDER:		PRN & PREMEDICATIONS:		
Please include MEDICATION, DOSE, FREQUENCY, DURATION and any ADDITIONAL administration INSTRUCTIONS specific to the primary therapy.  Vyvgart 10 mg/kg IV, once weekly, for 4 weeks.  <i>*(Patients greater than 120 kg will receive the max recommended dose of 1200 mg per infusion. subsequent treatment cycles to be based on clinical evaluation and ordered accordingly)</i>  Other: _____  FIRST DOSE:      Y      N  <input checked="" type="checkbox"/> Refill x12 months unless otherwise noted.		MEDICATIONS	30 minutes prior to every infusion	PRN
		Acetaminophen 650 mg PO		PRN every ____ hour for mild or moderate infusion reaction.
		Diphenhydramine 25 mg PO		PRN every ____ hour for mild or moderate infusion reaction.
		Diphenhydramine 25 mg IV		PRN every ____ hour for mild or moderate infusion reaction.
		Methylprednisolone 125 mg IV		PRN every ____ hour for mild or moderate infusion reaction.
		Other: _____		PRN every ____ hour for mild or moderate infusion reaction.
LINE USE/CARE ORDERS:		ADVERSE REACTION & ANAPHYLAXIS ORDERS:		
<input checked="" type="checkbox"/> START PIV/ACCESS CVC <input checked="" type="checkbox"/> FLUSH DEVICE PER FLEXCARE INFUSION POLICY & PROCEDURE (SEE REVERSE SIDE)  OTHER FLUSH ORDERS: (please fax other reaction orders if checking this box)		<input checked="" type="checkbox"/> ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side)  OTHER: (please fax other reaction orders if checking this box)		
PRESCRIBER INFORMATION: <u>Please check preferred form of communication.</u>				
PHYSICIAN NAME:		PHONE:		
OFFICE CONTACT:		FAX:		
ADDRESS:		EMAIL:		
CITY, STATE, ZIP:		NPI:		
(GENERIC SUBSTITUTION PERMITTED) PHYSICIAN SIGNATURE: _____		DATE: _____		
(DISPENSE AS WRITTEN) PHYSICIAN SIGNATURE: _____		DATE: _____		

# VYVGART REFERRAL FORM

## FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

*\*This table does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INFUSION REACTION	MODERATE INFUSION REACTION	SEVERE INFUSION REACTION/ANAPHYLAXIS
<b>SYMPTOM CLASSIFICATION</b>	<ul style="list-style-type: none"> <li>Flushing</li> <li>Dizziness</li> <li>Headache</li> <li>Apprehension</li> <li>Diaphoresis</li> <li>Palpitations</li> <li>Nausea / Vomiting</li> <li>Pruitis</li> </ul>	<ul style="list-style-type: none"> <li>Chest Tightness</li> <li>Shortness of Breath</li> <li>Hypo/hypertension (&gt;20 mmHg Change in Systolic BP from Baseline)</li> <li>Increased Temperature (&gt;2 Degrees Fahrenheit)</li> <li>Urticaria</li> </ul>	<ul style="list-style-type: none"> <li>Hypo/hypertension (&gt;40 mmHg Change in Systolic BP from Baseline).</li> <li>Increase Temperature (&gt;2 Degrees Fahrenheit) with Rigors</li> <li>Shortness of Breath with Wheezing</li> <li>Laryngeal Edema</li> <li>Chest Pain</li> <li>Hypoxemia</li> </ul>
<b>TREATMENT PROTOCOL FOR ADULTS &gt;66LBS</b>	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midanterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
<b>TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS</b>	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min <input checked="" type="checkbox"/> Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

**FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.**

## FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium	
		0.9% Sodium Chloride		10 Units/mL	100 Units/mL
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*
<b>ADULT &gt; 66 LBS</b>	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	10 mL	10 mL	5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL
<b>PEDIATRIC 33 LBS - 66 LBS</b>	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	5 mL	10 mL	3 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL

**FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.**

\*0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.