ADVANCED
INFUSION CENTER

Vyvgart Infusion Order Form

Name: _____DOB: _____

Allergies: _____ Referral date: _____

- Change dose for weight change of greater than 10% Patient Wt._____lbs. or Kg

Diagnosis/ ICD-10 Code: check one

- G70.00 Myasthenia gravis w/o (acute) exacerbation
- G70.01 Myasthenia gravis with (acute) exacerbation
- Generalized myasthenia gravis (gMG) anti-acetylcholine receptor (AChR) antibody
  positive

Medication Orders: check one

- Vyvgart 10mg/kg ____mg (based on Wt.); weekly x 4 weeks
- Vyvgart 10mg/kg 1200mg for patients greater than 120kg; weekly x 4 weeks
- Vyvgart 10mg/kg

_____

Nursing orders:

- Infuse over 1 hour via 0.2mg micron in-line filter
- Dilute in 0.9% sodium chloride for a total of 125ml
- Monitor patient during administration and for 1 hour post infusion for signs and symptoms of hypersensitivity reactions

Additional orders:

4362 Auburn Blvd., Sacramento, CA 95841
1215 Plumas St. Ste 1300B Yuba City, CA 95991
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