KAISER PERMANENTE®

Kaiser Permanente Washington Home Infusion Pharmacy (KPWAHIP)
efgartigimod alfa and hyaluronidase-qvfc (VYVGART® HYTRULO) Prescription Referral Form
Phone: (206) 326-2990 **Fax Referral To: (206) 326-2139**

1 PATIENT INFORMATION

Patient Name: _____
Phone: _____
Address: _____
City:_____**State:**_____**Zip:**_____
MRN #: _____
DOB: _____
Drug Allergies: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
DEA#: _____**NPI:** _____
Clinic/Facility Name: _____
Address: _____
City: _____**State:** _____**ZIP:** _____
_____
Phone: _____**Fax:** _____

3 Instructions to Provider

All orders with ✓ will be placed unless otherwise noted. Please fax completed order form to 206-326-2139. For drug prior authorization, call 1-888-767-4670 or visit https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice

4 CLINICAL INFORMATION

Diagnosis (ICD-10 code): _____ **Date of Last Dose:** _____

5 Efgartigimod alfa and hyaluronidase-qvfc (VYVGART® HYTRULO) PRESCRIPTION INFORMATION

Efgartigimod alfa and hyaluronidase-qvfc (VYVGART® HYTRULO) 1008 mg and 11,200 units/5.6 mL Route: Subcutaneous
Weight: _____ kg Date: _____
Dose: ☐ **1,008 mg efgartigimod alfa/11,200 units hyaluronidase**
Frequency per treatment cycle: ☐ **once weekly for** 4 **weeks**
Treatment cycle: every ____ days from first dose of pervious treatment cycle (no sooner than 50 days)
Duration/Refills: ____
First Dose: □ No □ Yes
Directions: Administer using **a 25G, 12-inch tubing, PVC winged infusion set** with a maximum priming volume of 0.4 mL. Before administration, attach syringe to winged infusion set; fill tubing of the infusion set by gently pressing syringe plunger until plunger is at 5.6 mL; there should be solution at the end of the infusion set needle. Choose an injection site on abdomen a minimum of 2 to 3 inches from the navel, 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**.

Infusion Reaction Medications & Supplies

- ✓ **Hydrocortisone sodium succinate injectable 100 mg IV or IM**
  Sig: Once PRN for hypersensitivity
- ✓ **Epinephrine Auto-Injector** ☐ 0.15mg ☐ 0.3mg **QTY:** 2
  Sig: Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use.
- ✓ **Diphenhydramine injectable 25 mg IV or IM**
  Sig: Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath
- ✓ **Sodium Chloride 0.9% IV 250 ml Bag IV**
  Sig: Once PRN for anaphylaxis

Labs /Special Instructions/Pre-Meds: _____
_____
_____

Infusion Protocol:

- Infuse per manufacturer guidelines
- Monitor vital signs (Temp, BP, HR, RR) during infusion and for 60 minutes following completion of infusion.
- Documentation must include:
  - Start and end time of infusion
  - Vital signs (including initial and final sets)
  - Patient response
- Observe patient for signs of infusion rate-related adverse reactions:
  - Blood pressure changes, increased pulse rate
  - Fever, chills
  - Headache
  - Chest, back or hip pain
  - Dyspnea
  - Mild erythema

6 PHYSICIAN SIGNATURE REQUIRED

X	X
SUBSTITUTION PERMITTED *(Date)*	DISPENSE AS WRITTEN (Date)

Members with Medicare Part B or D coverage are not required to use this form.