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| <b>1 PATIENT INFORMATION</b><br>Patient Name: _____<br>Phone: _____<br>Address: _____<br>City: _____ State: _____ Zip: _____<br>MRN #: _____<br>DOB: _____<br>Drug Allergies: _____   | <b>2 PRESCRIBER INFORMATION</b><br>Prescriber's Name: _____<br>DEA#: _____ NPI: _____<br>Clinic/Facility Name: _____<br>Address: _____<br>City: _____ State: _____ ZIP: _____<br>Phone: _____ Fax: _____  |   |  |
| <b>3 Instructions to Provider</b><br>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 <a href="https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice">https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice</a>   |   |   |  |
| <b>4 CLINICAL INFORMATION</b><br>Diagnosis (ICD-10 code): _____ Date of Last Dose: _____  |   |   |  |
| <b>5 Efgartigimod alfa and hyaluronidase-qvfc (VYVGART® HYTRULO) PRESCRIPTION INFORMATION</b><br>Efgartigimod alfa and hyaluronidase-qvfc (VYVGART® HYTRULO) 1008 mg and 11,200 units/5.6 mL <span style="float: right;">Route: Subcutaneous</span><br>Weight: _____ kg Date: _____<br>Dose: <input type="checkbox"/> 1,008 mg efgartigimod alfa/11,200 units hyaluronidase<br>Frequency per treatment cycle: <input type="checkbox"/> once weekly for 4 weeks<br>Treatment cycle: every _____ days from first dose of previous treatment cycle (no sooner than 50 days)<br>Duration/Refills: _____<br>First Dose: <input type="checkbox"/> No <input type="checkbox"/> Yes<br><b>Directions:</b> Administer using a <b>25G, 12-inch tubing, PVC winged infusion set</b> 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. <b>Administer over a period of 30 to 90 seconds.</b><br><br><b>Infusion Reaction Medications &amp; Supplies</b><br><table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input checked="" type="checkbox"/> <b>Hydrocortisone sodium succinate injectable 100 mg IV or IM</b><br/> <b>Sig:</b> Once PRN for hypersensitivity<br/> <input checked="" type="checkbox"/> <b>Epinephrine Auto-Injector</b> <input type="checkbox"/> 0.15mg <input type="checkbox"/> 0.3mg <b>QTY: 2</b><br/> <b>Sig:</b> Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use.                 </td> <td style="width: 50%; vertical-align: top;"> <input checked="" type="checkbox"/> <b>Diphenhydramine injectable 25 mg IV or IM</b><br/> <b>Sig:</b> Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath<br/> <input checked="" type="checkbox"/> <b>Sodium Chloride 0.9% IV 250 ml Bag IV</b><br/> <b>Sig:</b> Once PRN for anaphylaxis                 </td> </tr> </table> Labs /Special Instructions/Pre-Meds: _____<br>_____<br>_____ |   | <input checked="" type="checkbox"/> <b>Hydrocortisone sodium succinate injectable 100 mg IV or IM</b><br><b>Sig:</b> Once PRN for hypersensitivity<br><input checked="" type="checkbox"/> <b>Epinephrine Auto-Injector</b> <input type="checkbox"/> 0.15mg <input type="checkbox"/> 0.3mg <b>QTY: 2</b><br><b>Sig:</b> Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use. | <input checked="" type="checkbox"/> <b>Diphenhydramine injectable 25 mg IV or IM</b><br><b>Sig:</b> Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath<br><input checked="" type="checkbox"/> <b>Sodium Chloride 0.9% IV 250 ml Bag IV</b><br><b>Sig:</b> Once PRN for anaphylaxis |
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| <b>Infusion Protocol:</b> <ul style="list-style-type: none"> <li>• Infuse per manufacturer guidelines</li> <li>• Monitor vital signs (Temp, BP, HR, RR) during infusion and for 60 minutes following completion of infusion.</li> <li>• Documentation must include:                         <ul style="list-style-type: none"> <li>○ Start and end time of infusion</li> <li>○ Vital signs (including initial and final sets)</li> <li>○ Patient response</li> </ul> </li> </ul>  | <ul style="list-style-type: none"> <li>• Observe patient for signs of infusion rate-related adverse reactions:                         <ul style="list-style-type: none"> <li>○ Blood pressure changes, increased pulse rate</li> <li>○ Fever, chills</li> <li>○ Headache</li> <li>○ Chest, back or hip pain</li> <li>○ Dyspnea</li> <li>○ Mild erythema</li> </ul> </li> </ul> |   |  |
| <b>6 PHYSICIAN SIGNATURE REQUIRED</b>   |   |   |  |
| X<br>_____<br>SUBSTITUTION PERMITTED <span style="float: right;">(Date)</span>  | X<br>_____<br>DISPENSE AS WRITTEN <span style="float: right;">(Date)</span>   |   |  |

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