

Monday – Friday, 8 a.m. – 11 p.m.,  
and Saturday, 8 a.m. – 6:30 p.m., Eastern time

Date: \_\_\_\_\_

**Patient information**

Patient name: \_\_\_\_\_

Patient address: \_\_\_\_\_

Patient phone number: \_\_\_\_\_

Member ID: \_\_\_\_\_

Patient date of birth: \_\_\_\_\_

Allergies:  No known allergies \_\_\_\_\_Current weight: \_\_\_\_\_  lbs  kg**Primary diagnosis:** G70.00: Myasthenia gravis without (acute) exacerbation G70.01: Myasthenia gravis with (acute) exacerbation G61.81: Chronic inflammatory demyelinating polyneuritis Other: \_\_\_\_\_**Clinical documents (please attach)**

History and physical and progress notes within past six months

Venous access:  Peripheral  Port  PICC  SQ Other: \_\_\_\_\_ Gravity as tolerated by patient  Pump: \_\_\_\_\_Has prescriber initiated prior authorization?  Yes  NoFirst dose?  Yes  No

Expected date of first/next infusion: \_\_\_\_\_

Site of care:  Patient's home  Physician's office Outpatient infusion clinic: \_\_\_\_\_

Prescriber signature: \_\_\_\_\_

Date: \_\_\_\_\_

Prescriber name: \_\_\_\_\_

Prescriber address: \_\_\_\_\_

DEA number: \_\_\_\_\_

NPI number: \_\_\_\_\_

Prescriber phone number: \_\_\_\_\_

Prescriber fax number: \_\_\_\_\_

**Supervising prescriber information (if applicable):**

Prescriber name: \_\_\_\_\_

Prescriber address: \_\_\_\_\_

Prescriber phone number: \_\_\_\_\_

DEA number: \_\_\_\_\_

NPI number: \_\_\_\_\_

Note: If all information is not completed, we cannot process the patient request. We will contact your office for clarification.

You can send this prescription electronically by selecting "CenterWell Specialty Pharmacy" (National Council for Prescription Drug Programs [NCPDP] ID number 3677955) from the list of pharmacies on your e-prescribing tool.

**Prescription information**

Please check appropriate box.

 Vyvgart® 400 mg/20 mL single-dose vial

Generalized myasthenia gravis (gMG)

Infuse \_\_\_\_\_ mg IV once weekly for 4 weeks.

In patients weighing 120 kg or more, the recommended dose is 1,200 mg/infusion.

**Administer treatment cycle once weekly for 4 weeks on then \_\_\_\_\_ weeks off.****We may round to the nearest gram vial size.** Vyvgart Hytrulo® PFS 1,000 mg/10,000 units/5 mL gMG

Inject 1,000 mg/10,000 units SQ once weekly for 4 weeks.

**Administer treatment cycle once weekly for 4 weeks on then \_\_\_\_\_ weeks off.** Chronic inflammatory demyelinating polyneuritis

Inject 1,000 mg/10,000 units SQ once weekly.

 Vyvgart Hytrulo SDV 1,008 mg/11,200 units/5.6 mL gMG

Inject 1,008 mg/11,200 units SQ once weekly for 4 weeks.

**Administer treatment cycle once weekly for 4 weeks on then \_\_\_\_\_ weeks off.** Chronic inflammatory demyelinating polyneuritis

Inject 1,008 mg/11,200 units SQ once weekly.

**Quantity:** 28-day supply **Refill** for one year or \_\_\_\_\_**Pharmacy to dispense ancillary supplies as needed to establish IV and administer medication, including coordination of home health nursing unless otherwise noted.****Please strike-through items that are not required:***normal saline 10 mL IV flush syringe***Directions:** Use as directed to flush line with 10 mL before and after infusion and P.R.N. line care.*heparin 100 unit/mL 5 mL prefilled syringe (central line patients)***Directions:** Use as directed to flush line with 5 mL after final saline flush.  
*sodium chloride 0.9% 150 mL***Directions:** Use as directed to further dilute Vyvgart to a total volume of 125 mL.  
*sodium chloride 0.9% 50 mL***Directions:** Use as directed to flush entire line after Vyvgart Infusion.**Premedications (Please strike-through items that are not required.):** *lidocaine/prilocaine cream 2.5%-2.5%* **Quantity:** 30 grams**Refill** for one year or \_\_\_\_\_ **Directions:** Apply topically to needle insertion site 30–60 minutes prior to needle insertion as directed.**Other:** \_\_\_\_\_**Anaphylaxis kit maintained in the patient's home:***diphenhydramine 50 mg/mL injection* **Quantity:** One vial **Refills:** 0**Directions:** Use as directed via slow IV push as needed for anaphylaxis.*diphenhydramine 25 mg capsules* **Quantity:** 10 capsules **Refills:** 0**Directions:** Take 25–50 mg PO as needed for anaphylaxis.*epinephrine two-pack 0.3 mg or epinephrine two-pack 0.15 mg (for patients weighing 15–30 kg)* **Quantity:** Two-pack **Refills:** 0**Directions:** Use as directed IM as needed for anaphylaxis.**Skilled home infusion nursing visit will establish venous access, provide patient education related to therapy and disease state, administer medication as prescribed, and assess general status and response to therapy. The visit frequency is based on prescribed dosage orders.**