



INFUSION SUITE		VYVGART INFUSION ORDERS	
Durango Infusion Center 270 E 8th Ave Ste N101 Durango, CO 81301		Phone: 970-828-3500	Fax: 970-828-3501
<b>PATIENT INFORMATION - Include Patient Demographics and Insurance Cards</b>			
Name:		DOB:	
<b>MEDICAL INFORMATION</b>			
ICD10:		Patient Height:	
Patient Weight (kg):		Allergies:	
*Weigh patient prior to each infusion			
<b>REQUIRED TESTING</b>			
<input type="checkbox"/> AChR+ antibody: _____ <input type="checkbox"/> MG-ADL Score: _____			
Additional labs: _____			
<input type="checkbox"/> Insert IV	<input type="checkbox"/> Access Port/PICC		
<b>PREMEDICATIONS 30 minutes prior to starting</b>			
<input type="checkbox"/> Acetaminophen:	<input type="checkbox"/> 325mg PO X1	<input type="checkbox"/> 500mg PO X1	<input type="checkbox"/> 650mg PO X1 <input type="checkbox"/> 1000mg PO X1
<input type="checkbox"/> Diphenhydramine:	<input type="checkbox"/> 25mg IV X1	<input type="checkbox"/> 25mg PO X1	<input type="checkbox"/> 50mg IV X1 <input type="checkbox"/> 50mg PO X1
<input type="checkbox"/> Solumedrol:	<input type="checkbox"/> 40mg IV X1	<input type="checkbox"/> 100mg IV X1	<input type="checkbox"/> 125mg IV X1
<input type="checkbox"/> Antihistamine:	<input type="checkbox"/> Cetirizine 10mg PO X1 <input type="checkbox"/> Loratadine 10mg PO X1		
<input type="checkbox"/> Additional PRN:	_____		
<b>VYVGART ORDERS</b>			
<input type="checkbox"/> Weight <120KG:	Vyvgart 10mg/kg IV in NS over 1 hour weekly X 4 weeks		
<input type="checkbox"/> Weight >120KG:	Vyvgart 1200mg IV in NS over 1 hour weekly X 4 weeks		
<b>POST INFUSION</b>			
<input type="checkbox"/> Flush IV line with 25mL NS at the same rate of infusion. D/C IV.			
<input type="checkbox"/> Flush IV line with 25 mL NS. Flush port with 10mL NS, Lock port with 5mL Heparin 10-100U/mL and deaccess			
<input type="checkbox"/> Discharge after 1 hour observation time			
<input type="checkbox"/> Discharge home without observation time			
Referring Provider Printed:	_____		
Referring Provider Signature:	_____	Date:	_____
Referring Provider Phone:	_____	Referring Provider Fax:	_____
DNG Provider Printed:	_____		
DNG Provider Signature:	_____	Date:	_____

*\*Credentials must be included*

**Infusion Directions:**

- Calculate the dose (mg), total drug volume (mL) of solution required, and the number of vials needed based on the recommended dose according to the patient's body weight
- Gently withdraw the calculated dose from the vial(s) with a sterile syringe and needle.
- Dilute the medication with 0.9% Sodium Chloride Injection, USP to make a total volume of 125 mL.
- Gently invert the infusion bag containing the diluted medication without shaking.
- Infuse over 1 hour using 0.2 micron in-line filter tubing