Holland Hospital

AMBULATORY TREATMENT UNIT

Ambulatory Treatment Unit
Phone (616) 394-3547
Fax (616) 394-2139

Vyvgart (efgartigimod alfa) Order Set

☐ = Optional Order ● = Routine Order (Cross out and initial **BULLETED ORDERS** that do not apply)

ORDERS

Date: _____ **Time:** _____ **Diagnosis Code: (ICD-10)** _____

Patient Name: _____ **Date of Birth:** _____ **Weight:** _____ (kg)

Allergies: _____

PRE-MEDICATIONS

When ordering pretreatment medication(s), please select appropriate formulation.

- ☐ Acetaminophen - *650 mg, Oral: Tab. Give prior to treatment.*
- ☐ Cetirizine (Zyrtec) 10 mg PO. *Give prior to treatment.*
- ☐ Methylprednisolone (Solu-Medrol) 40 mg IV Push. *Give prior to treatment.*
- ☐ Other: _____

MEDICATIONS

☑ Vyvgart (efgartigimod alfa) 10mg/kg (fixed dose mg not to exceed 1200mg) IV once weekly x4 doses (one cycle)

- Provider to determine frequency of cycles. Check **ONE**.
  - ☐ One cycle only (Provider to submit new referral when due for following cycle.)
  - ☐ Repeat cycle every 28 days from last dose for 6 total cycles for 12 months.
  - ☐ Repeat cycle every 28 days from last dose for total of _____ cycles.
- Other:_____

Nursing Considerations

- Infuse over 1 hour
- Use 0.2 micro inline filter
- Monitor for infusion related reactions for 1 hour post infusion
- Check for active infection. If there is an active infection, dose should be held. Contact provider for guidance whether to continue treatment.

Treatment for Adverse Drug Reactions (for mild to moderate infusion reaction)

- Slow or stop infusion for 20 minutes
- Give:
  - Diphenhydramine (Benadryl) 25 mg slow IVP STAT (may repeat times 1)
  - Acetaminophen (Tylenol) 650 mg PO STAT, if not already given as a "premedication". (Maximum acetaminophen doses of 4000 mg in 24 hours from all combined sources.)
  - Methylprednisolone (Solu-Medrol) 125 mg IVP STAT
- Place O_2 PRN at 4 – 6 liters per nasal cannula STAT
- Vital signs with PO_2 every 5 minutes until stable
- Notify the physician of reaction. Request further orders as indicated.
- Complete adverse drug reaction PowerForm and document in the allergy profile for all drug reactions.

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____