Vyvgart® & Vyvgart® Hytrulo Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: ____________ Ship To: Patient MD Office Other: ____________

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone:	Phone:
Cell Phone:	Fax:
Date of Birth: Gender:	DEA #: NPI #:
Emergency Contact: Phone:	Contact Person:

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: ____________ ID: ____________ Group: ____________
Secondary Insurance: ____________ ID: ____________ Group: ____________
Prescription Card: ____________ ID: ____________ BIN: ____________ PCN: ____________

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

G70.00 Myasthenia Gravis without (acute) exacerbation
G70.01 Myasthenia Gravis with (acute) exacerbation
G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

Patient's demographics, including insurance information
Clinical/Progress notes with supporting diagnosis
H&P

MG Indication:
Positive serologic test for anti-AChR antibody for gMG
MG-ADL Score: ____________ MGFA classification: ____________

CIDP Indication:
Biopsy Results Electromyography (EMG) Results CSF Studies
INCAT RODS mRS

Original Prescription Orders Attached

Previous therapies: eculizumab rituximab IVIG oral corticosteroids non-steroidal ISTs

MEDICAL HISTORY

Patient Weight: ________ kg lbs Height: ________ cm in
Allergies: ____________
Line Access: Peripheral PICC Port
Therapy Start Date: ____________ Therapy End Date: ____________
Current medications: ____________
Previous live vaccine: ____________ Date: ____________

Nursing Coordination:
Pharmacy to coordinate home health nursing visit as necessary: Yes No
Home health nursing coordination not necessary. Reason:
MD office to administer to patient
Home health nursing already coordinated

PRESCRIPTION INFORMATION

Vyvgart® (efgartigimod alfa-fcab) Prescription:	Dispense:
10mg/kg body weight weekly for 4 doses. (Once weekly x 4 weeks.) Maximum dose: 1.2gm. Subsequent treatment cycles may be administered based on clinical evaluation and no sooner than 50 days from the start of the previous treatment cycle.	4 doses
Subsequent treatment cycles to be determined	no refills
Subsequent treatment cycles to be every 50 days from the start of the previous treatment cycle	7 refills
Subsequent treatment cycles to be every ______ days from the start of the treatment cycle	____ refills
Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) Prescription for generalized Myasthenia Gravis:	
1,008 mg/11,200 units (5.6mL) subcutaneous injection over 30-90 seconds once weekly for 4 weeks. Subsequent treatment cycles based on clinical evaluation; no sooner than 50 days from the start of the previous treatment cycle. To be administered by a healthcare professional with 30 minutes post observation period.	4 doses
Subsequent treatment cycles to be determined	no refills
Subsequent treatment cycles to be every 50 days from the start of the previous treatment cycle	7 refills
Subsequent treatment cycles to be every ______ days from the start of the treatment cycle	____ refills
Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) Prescription for Chronic Inflammatory Demyelinating Polyneuropathy (CIDP):	
1,008 mg/11,200 units (5.6mL) subcutaneous injection over 30-90 seconds once weekly. To be administered by a healthcare professional with 30 minutes post observation period.	4 doses 12 refills

ORDERS/OTHER MEDICATIONS

- **Orders are initiated:**
- Infusion supplies as per protocol
- Anaphylaxis Kit orders as per protocol

Flush Protocol (For Vyvgart® intravenous infusion only)
- NaCl 0.9% 10mL
- Before and after infusion

Other: ____________

Prescriber Signature: ____________ **Date:** ____________

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