InfuCare Rx®

Vyvgart® & Vyvgart Hytrulo® Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940
argenx-referral@infucarerx.com

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

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
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

Indication:	Drug/Strength:	Directions:	Quantity:	Refills:
☐ gMG	☐ Vyvgart® Vial 400mg/20mL IV: 10mg/kg (max 1.2gm) IV over one hour ☐ Vyvgart Hytrulo® Vial 1,008mg/11,200 units SUBQ over 30-90 seconds ☐ Vyvgart Hytrulo® PFS 1,000mg/10,000 units SUBQ over 20-30 seconds	☐ Once weekly for 4 doses (1 cycle). ☐ Administer subsequent treatment cycles according to clinical evaluation.	4 doses	____ or ☐ 1 year.
☐ CIDP	☐ Vyvgart Hytrulo® Vial 1,008 mg/11,200 units SUBQ over 30-90 seconds ☐ Vyvgart Hytrulo® PFS 1,000 mg/10,000 units SUBQ over 20-30 seconds	☐ Once weekly	4 doses	____ or ☐ 1 year.

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: _____

ADDITIONAL COMMENTS:

Prescriber Signature: _____ **Date:** _____

Revised 21 Dec 2025