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:
Anti-AChR Antibody Positive Anti-MuSK Antibody Positive
Triple seronegative Anti-LRP4 Antibody Positive
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) Subsequent treatment cycles to be determined Subsequent treatment cycles to be 4 weeks on with ______ weeks between trreatment cycles	4 doses = 1 cycle	____ 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 = 1 cycle	____ or 1 year.

ORDERS/OTHER MEDICATIONS

- **Orders are initiated:**
- Infusion supplies as per protocol
- Anaphylaxis Kit orders as per protocol (not applicable for PFS formulation)

Flush Protocol (For Vyvgart® intravenous infusion only)

- NaCl 0.9% 10mL
- Before and after infusion

Other: ______________

ADDITIONAL COMMENTS:

Prescriber Signature: ______________ **Date:** ______________

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Revised 13 May 2026