

Vyvgart® & Vyvgart Hytrulo® Enrollment Form

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: 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
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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 treatment 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:	Flush Protocol (For Vyvgart® intravenous infusion only)
► Infusion supplies as per protocol	► NaCl 0.9% 10mL
► Anaphylaxis Kit orders as per protocol	► Before and after infusion Other: _____

ADDITIONAL COMMENTS:

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Prescriber Signature: _____ Date: _____



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