VYVGART® Hytrulo
(efgartigimod alfa and hyaluronidase-qvfc)
Subcutaneous Injection
180 mg/mL and 2000 U/mL vial

VYVGART®
(efgartigimod alfa-fcab)
Injection for Intravenous Use
400 mg/20 mL vial

Enrollment Form

To enroll patients, fax the completed form to My VYVGART Path at **1-833-MY-V-PATH (1-833-698-7284)**. Visit **MyPathEnroll.com** for more information.
For questions, please contact My VYVGART Path at **1-833-VYVGART (1-833-898-4278)**.
Office hours: Monday through Friday, 8 AM to 8 PM ET.

***Indicates required field.**

1. PATIENT INFORMATION

***Patient First Name:**	***Patient Middle Initial:**
***Patient Last Name:**	
***DOB (MM/DD/YYYY):**	***Patient Email:**
***Phone #:**	Alternate Phone #:
***Patient Mailing Address:**	
***City:**	***State:** / ***Zip:**

Patient Gender: ☐ Male ☐ Female ☐ Nonbinary

Patient-Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Is your patient new to VYVGART Hytrulo or VYVGART? ☐ Yes ☐ No

Authorized Caregiver or Alternate Contact: *By providing this information, you authorize My VYVGART Path to discuss the patient's health condition and participation in My VYVGART Path with the person named below.*

Caregiver First Name:	Caregiver Middle Initial:
Caregiver Last Name:	Relationship to Patient:
Caregiver Email:	Caregiver Phone Number:

2. INSURANCE INFORMATION

Please fax copies of both the front and back of all medical and prescription insurance cards.

Check here if the patient has no insurance: ☐

Co-Pay Program: ☐ Yes ☐ No

Patient Assistance Program : ☐ Yes ☐ No

	*Primary Benefit	Secondary Benefit	Pharmacy Benefit
***Insurance Name**			
***Policyholder Name:**			
***Policy ID #:**			
Relationship to Patient:			
Insurance Provider Phone #:			
Group #:			
PCN #:			
BIN #:			

3. PRESCRIBER INFORMATION

***Prescriber Name (First, Middle, Last):**

***Practice Name:**

*NPI #:	*Tax ID:	*State License #:	Medicare/Medicaid Provider #:

*Practice Address:	*City:	*State:	*Zip:

*Office Phone #:	*Office Fax #:	Prescriber Email:

Please provide direct contact information for an office contact who can handle access issues.

Office Contact Name:	Office Contact Phone #:	Office Contact Email:

For section 4. PRESCRIPTION INFORMATION, please complete either page 3 for generalized myasthenia gravis (gMG) or page 4 for chronic inflammatory demyelinating polyneuropathy (CIDP).

Patient Name: _____

4. ☐ *PRESCRIPTION INFORMATION: GENERALIZED MYASTHENIA GRAVIS (gMG)

*Patient First Name:	*Patient Middle Initial:	*Patient Last Name:	*DOB (MM/DD/YYYY):

*Site of Care Location: ☐ Prescribing physician's office ☐ Home injection ☐ Infusion center ☐ Hospital outpatient ☐ Patient's choice ☐ Specialty pharmacy ☐ Unknown

Preferred Site of Care Name:	Preferred Site of Care Address:
Specialty Pharmacy: ☐ Yes ☐ No	Preferred Specialty Pharmacy Name:
Buy and Bill: ☐ Yes ☐ No	Other Instructions:

*Primary Diagnosis ICD-10 Code: ☐ G70.00 (Myasthenia gravis without acute exacerbation) ☐ G70.01 (Myasthenia gravis with acute exacerbation)

*Anti-AChR Antibody Positive: ☐ Yes ☐ No

Patient Allergies:

Current Therapies: ☐ Treatment-naïve ☐ Mestinon ☐ Nonsteroidal ISTs ☐ Oral corticosteroids ☐ Zilucoplan ☐ Other ☐ Rituximab ☐ Eculizumab ☐ Rozanolixizumab ☐ Ravulizumab-cwvz ☐ IVIg

Previous Therapies: ☐ Treatment-naïve ☐ Mestinon ☐ Nonsteroidal ISTs ☐ Oral corticosteroids ☐ Zilucoplan ☐ Other ☐ Rituximab ☐ Eculizumab ☐ Rozanolixizumab ☐ Ravulizumab-cwvz ☐ IVIg

Current MG-ADL Score (Optional):_____
MG-ADL=Myasthenia Gravis Activities of Daily Living

MGFA Classification (Optional):_____
MGFA=Myasthenia Gravis Foundation of America

Please check for preferred VYVGART treatment. Complete the applicable prescription information section(s) based on this selection.

☐ VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection

VYVGART Hytrulo is a fixed dose per injection.

Dosing	**1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL (180 mg/2,000 units per mL) in a single-dose vial**
Directions	Administer subcutaneously over approximately 30 to 90 seconds once weekly for 4 weeks (4 once-weekly injections = 1 treatment cycle) with _____ weeks between treatment cycles.
Refills	***Number of Refills (Treatment Cycles) Authorized:** _____ (4 once-weekly injections = 1 treatment cycle)

☐ VYVGART (efgartigimod alfa-fcab) for intravenous use

VYVGART is weight based. For assistance, visit vyvgarthcp.com/dosing/vyvgart.

Dosing	**10 mg/kg x patient weight (kg) = dose (mg)** **Strength:** 400 mg/20 mL (20 mg/mL) in a 20 mL single-dose vial **Calculated Dose:** ***Patient Weight:** _____ **kg** *To convert from lb to kg, divide the patient's weight in lb by 2.205. For patients weighing 120 kg or more, the dose should not exceed 1,200 mg (3 vials) per infusion.* ☐ _____ **mg based on weight** ☐ **1,200 mg for patients greater than 120 kg**
Directions	Infuse once weekly for 4 weeks (4 once-weekly infusions = 1 treatment cycle) with _____ weeks between infusion cycles.
Refills	***Number of Refills (Treatment Cycles) Authorized:** _____ (4 once-weekly infusions = 1 treatment cycle)

Additional Instructions:

PRESCRIBER AUTHORIZATION AND ATTESTATION

By signing below, I certify that I am prescribing VYVGART Hytrulo or VYVGART for the patient identified herein, and that I have received permission from the patient and met other applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and applicable state laws needed to release the information that I am providing in this enrollment form. I understand that such information may be used by My VYVGART Path, its designated agents, service providers, and dispensing pharmacies for the purposes of verifying the patient's insurance coverage for VYVGART Hytrulo or VYVGART, confirming prior authorization requirements for VYVGART Hytrulo or VYVGART, if needed, on my patient's behalf, providing information to my office or the patient on appeals of denials of claims, coordinating delivery of VYVGART Hytrulo or VYVGART, and providing my patient with other education and support. I authorize My VYVGART Path, its affiliates, agents, and contractors to act on my behalf for the limited purposes of transmitting this prescription, by any means allowed under applicable law, to the appropriate pharmacy designated by the patient utilizing their benefit plan.
ATTN: New York and Iowa providers, please submit an electronic prescription.

"Dispense As Written"/Brand Medically Necessary/Do Not Substitute/No Substitution/DAW/May Not Substitute

*Prescriber Signature: _____ *Date (MM/DD/YYYY): _____

4. ☐ *PRESCRIPTION INFORMATION:
CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP)

VYVGART Hytrulo only

***Patient First Name:**	***Patient Middle Initial:**
***Patient Last Name:**	***DOB (MM/DD/YYYY):**

***Site of Care Location:** ☐ Prescribing physician's office ☐ Home injection ☐ Infusion center ☐ Hospital outpatient ☐ Patient's choice ☐ Specialty pharmacy ☐ Unknown

Preferred Site of Care Name:	Preferred Site of Care Address:
Specialty Pharmacy: ☐ Yes ☐ No	Preferred Specialty Pharmacy Name:
Buy and Bill: ☐ Yes ☐ No	Other Instructions:

***Primary Diagnosis ICD-10 Code:** ☐ G61.81	Patient Allergies:

Current Therapies: ☐ Treatment-naïve ☐ IVIg ☐ Corticosteroids ☐ SCIg ☐ Other

Previous Therapies: ☐ Treatment-naïve ☐ IVIg ☐ Corticosteroids ☐ SCIg ☐ Other

☐ **VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection**

VYVGART Hytrulo is a fixed dose per injection.

Dosing	**1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL (180 mg/2,000 units per mL) in a single-dose vial**
Directions	Administer subcutaneously over approximately 30 to 90 seconds once weekly.
Refills	***Dispense Quantity:** _____ *(Dispensed as single-dose vials)* ***Refills:** _____

Additional Instructions:

PRESCRIBER AUTHORIZATION AND ATTESTATION

By signing below, I certify that I am prescribing VYVGART Hytrulo for the patient identified herein, and that I have received permission from the patient and met other applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and applicable state laws needed to release the information that I am providing in this enrollment form. I understand that such information may be used by My VYVGART Path, its designated agents, service providers, and dispensing pharmacies for the purposes of verifying the patient's insurance coverage for VYVGART Hytrulo, confirming prior authorization requirements for VYVGART Hytrulo, if needed, on my patient's behalf, providing information to my office or the patient on appeals of denials of claims, coordinating delivery of VYVGART Hytrulo, and providing my patient with other education and support. I authorize My VYVGART Path, its affiliates, agents, and contractors to act on my behalf for the limited purposes of transmitting this prescription, by any means allowed under applicable law, to the appropriate pharmacy designated by the patient utilizing their benefit plan.

ATTN: New York and Iowa providers, please submit an electronic prescription.

"Dispense As Written"/Brand Medically Necessary/Do Not Substitute/No Substitution/DAW/May Not Substitute

***Prescriber Signature:** _____ ***Date (MM/DD/YYYY):** _____

5. PATIENT AUTHORIZATION TO COLLECT, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION

By signing below, I authorize my healthcare providers, pharmacies, and health plans (collectively, my "Health Team") to: disclose my personal health information ("PHI"), including my medical condition, prescription, and insurance coverage, to argenx, its affiliates, contractors, and agents, in order for them to use and share with my Health Team as needed to enroll me in My VYVGART Path; conduct benefits investigations and take related actions to determine my eligibility for, and coordinate financial assistance for me to receive VYVGART Hytrulo or VYVGART; communicate with my Health Team about my treatment plan; provide me with support services, including disease state and VYVGART Hytrulo or VYVGART education and resources; help facilitate prescription and refill fulfillment; facilitate quality control and related reporting activities; use my de-identified data for research and publication; conduct data analytics, market research, and My VYVGART Path–related business activities; and/or contact me about My VYVGART Path services. I understand that once my PHI has been disclosed to argenx, it may no longer be protected by federal privacy law and could be re-disclosed to others; I can withdraw this authorization by calling 833-697-2841 or mailing notice of revocation to My VYVGART Path, 680 Century Point, Suite 1000, Lake Mary, FL 32746; revocation will take effect when My VYVGART Path receives my notice of revocation, but uses and disclosures made in reliance on the authorization prior to its revocation will not be invalidated; my healthcare treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my signing this authorization; this authorization expires 10 years after signing or on such earlier date as state law may require and I am entitled to receive a copy of this authorization after I sign it. A disclosing party may receive remuneration in exchange for PHI if our relationship involves receipt of compensation in exchange for data or in connection with providing PHI pursuant to an authorization. I understand that I am entitled to submit a written request to argenx for a copy of this consent language, along with any disclosed PHI. I further authorize argenx to contact any individual(s) identified as an Authorized Caregiver (below) to discuss my medical condition or my participation in My VYVGART Path, and I understand that such discussions may require argenx to disclose my PHI to such Authorized Caregiver.

***Patient Name:**	***DOB (MM/DD/YYYY):**
***Patient Signature:**	***Date Signed (MM/DD/YYYY):**

Authorized Caregiver Name and Phone #:

☐ *Check here to receive patient education program information, engagement communication requests from argenx, and emails promoting argenx products and services.*

☐ *Check here to consent to mobile messaging promoting argenx products and services. Message and data rates may apply.*

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