Myasthenia Gravis Subcutaneous Enrollment Form

Fax Referral To: 1-855-297-1270 **Phone:** 1-888-280-1190
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927 **NCPDP:** 4026325

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: ____ DOB: _______________ Gender: ☐ Male ☐ Female
Address: ____City, State, ZIP Code: ______________________________
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: ____ Alternate Phone: _________________________________
Email: ____ Last Four of SSN: ________ Primary Language: _________________
Parent/Caregiver/Legal Guardian Name (Last, First): ________________**Relationship to patient**: _________________________

2 PRESCRIBER INFORMATION

Prescriber's Name: ____ State License #: ______________________________________
NPI #: ___________ DEA #: ___________ Group or Hospital: ____
Address: ____ City, State, ZIP Code: ____
Phone: ______________________ Fax: ______________ Contact Person: ___________________ Contact's Phone: _________________

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: __________________________ Ship to: ☐ Patient ☐ Office ☐ Other: ______________________________________

Diagnosis (ICD-10):
☐ G70.00 Myasthenia Gravis without (acute) exacerbation ☐ G70.01 Myasthenia Gravis with (acute) exacerbation
☐ Other Code: _____________ Description: ____

Patient Clinical Information:
Allergies: ____ Weight: ________lb/kg Height: _______In/cm
Prior therapy, treatment dates, and reason(s) for discontinuation: ____
Treatment status: ☐ New to therapy ☐ Continuation of therapy; date of last treatment ___/__/____ Needs by date: __________________
MG-ADL Score: __________ Date of assessment: _____________
AChR Antibody Test: ☐ Positive ☐ Negative ☐ Not Known
MuSK Antibody Test: ☐ Positive ☐ Negative ☐ Not Known

Nursing and Administration:
Specialty pharmacy to coordinate home health Infusion nurse visit as necessary? ☐Yes ☐No

Patient Administration Location:
☐ Prescribing physician office** ☐ Home injection/infusion*
☐ Coram Ambulatory Infusion Suite (AIS)* ☐ Other infusion center ____________________

*** FOR RYSTIGGO** – Pump, Supplies, Nursing services for drug administration
*** FOR VYVGART HYTRULO –** Supplies & Nursing services for drug administration
**Prescriber's Office/Other Infusion Clinic: Drug only for facility administration

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Please Complete Patient, Prescriber, and Clinical Information

Patient Name: ____________________ Patient DOB: ________________ Patient Phone: ______________

Prescriber Name: ____________________________ Prescriber Phone: ______________________________

Patient Clinical Information:

Allergies: ____________________________ Weight: ____________lb/kg Height: ________in/cm

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Rystiggo	280 mg/2 mL (140 mg/mL)	☐ **Patients weighing less than 50 kg** Administer 420 mg (3 mL) as a subcutaneous infusion using an infusion pump at a rate of up to 20 mL/hr once weekly for 6 weeks (1 cycle). Discard remainder ☐ **Patients weighing 50 kg to less than 100 kg** Administer 560 mg (4 mL) as a subcutaneous infusion using an infusion pump at a rate of up to 20 mL/hr once weekly for 6 weeks (1 cycle) ☐ **Patients weighing 100 kg and above** Administer 840 mg (6 mL) as a subcutaneous infusion using an infusion pump at a rate of up to 20 mL/hr once weekly for 6 weeks (1 cycle) Administer subsequent treatment cycles based on clinical evaluation. The safety of initiating subsequent cycles sooner than 63 days from the start of the previous treatment cycle has not been established.	Initiation of Last Cycle Date: ___________ Quantity Sufficient of vials (1 cycle) Number of refills (Treatment cycles) authorized: __________ *1 cycle = 6 weekly Infusions
☐ Vyvgart Hytrulo	1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL	**Directions:** Administer 4 weekly injections (1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per week) subcutaneously over approximately 30-90 seconds. Administer subsequent treatment cycles according to clinical evaluation. The safety of initiating subsequent cycles sooner than 50 days from the start of the previous treatment cycle has not been established.	Initiation of Last Cycle Date: ___________ Quantity Sufficient of vials (1 cycle) Number of refills (Treatment cycles) authorized: __________ *1 cycle = 4 weekly injections

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature:** ____________________**Date:** _______	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature:** ____________________**Date:** ______

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" ____________ **ATTN New York and Iowa providers:** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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Prescriber Name: ____________________________________ Prescriber Phone: _____________________________________

Patient Clinical Information:

Allergies: ____________________________________ Weight: _______________lb/kg Height: __________in/cm

Nursing Medications

Complete items below, required for Home Infusion

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ 1:1000, 0.3 mg/0.3 mL (greater than 30 kg/66lbs) ☐ 1:1000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs) ☐ 1:1000, 0.01 mg/kg, Max 0.3 mg (under 15 kg) Mild-Moderate Reactions. May repeat in 3-5 minutes as needed For severe allergic reaction also call 911	Quantity: __________ Refills: ____________

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