

# Myasthenia Gravis Subcutaneous Enrollment Form



Fax Referral To: 1-800-323-2445

Phone: 1-800-378-0695

## 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

# Myasthenia Gravis Subcutaneous Enrollment Form

## 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
<input type="checkbox"/> Rystiggo	280 mg/2 mL (140 mg/mL)	<input type="checkbox"/> <b>Patients weighing less than 50 kg</b> 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  <input type="checkbox"/> <b>Patients weighing 50 kg to less than 100 kg</b> 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)  <input type="checkbox"/> <b>Patients weighing 100 kg and above</b> 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
<input type="checkbox"/> Vyvgart Hytrulo	1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL	<b>Directions:</b> 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.

# Myasthenia Gravis Subcutaneous Enrollment Form

## 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

## Nursing Medications

### Complete items below, required for Home Infusion

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Epinephrine **nursing requires**	<input type="checkbox"/> IM <input type="checkbox"/> SC	<input type="checkbox"/> 1:1000, 0.3 mg/0.3 mL (greater than 30 kg/66lbs) <input type="checkbox"/> 1:1000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs) <input type="checkbox"/> 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: _____

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 <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
---	--

**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.

**CONFIDENTIALITY NOTICE:** This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Health and/or one of its affiliates.