

Myasthenia Gravis Subcutaneous Enrollment Form



Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727
NCPDP: 1203417

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. 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: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____

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*
 Other Infusion Center Other _____

* **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

Other: _____

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Please Complete Patient, Prescriber, and Clinical Information

Patient Name: _____ Patient DOB: _____
 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)	<p><input type="checkbox"/> Patients weighing less than 50kg Administer 420 mg (3 mL) as a subcutaneous infusion using an infusion pump at a rate of up to 20mL/hr once weekly for 6 weeks (1 cycle). Discard remainder</p> <p><input type="checkbox"/> Patients weighing 50kg to less than 100kg 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)</p> <p><input type="checkbox"/> Patients weighing 100kg 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)</p> <p>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.</p>	<p>Initiation of Last Cycle Date: _____</p> <p>Quantity Sufficient of vials (1 cycle)</p> <p>Number of refills (Treatment cycles) authorized: _____</p> <p>*1 cycle = 6 weekly Infusions</p>
<input type="checkbox"/> Vyvgart Hytrulo	1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL	<p>Directions: Administer 4 weekly injections (1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per week) subcutaneously over approximately 30-90 seconds.</p> <p>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.</p>	<p>Initiation of Last Cycle Date: _____</p> <p>Quantity Sufficient of vials (1 cycle)</p> <p>Number of refills (Treatment cycles) authorized: _____</p> <p>*1 cycle = 4 weekly injections</p>

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Patient Name: _____ Patient DOB: _____
 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	Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	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 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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