Myasthenia Gravis Subcutaneous Enrollment Form

CVS specialty®

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. 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)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No
Policy Holder's Name: _____ Policy Holder's DOB: _____ Relationship to Patient: _____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____
Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #:_____
☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

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/injection training 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 VIALS –** Supplies & Nursing services for drug administration
*** FOR VYVGART HYTRULO PREFILLED SYRINGES –** Supplies & Nursing services for drug administration and self-administration training.
**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: _____
Patient Address: _____
Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ **Rystiggo**	☐ 420 mg/3 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	Initiation of Last Cycle Date: _____ Quantity Sufficient of vials (1 cycle) Number of refills (Treatment cycles) authorized: _____ *1 cycle = 6 weekly Infusions
	☐ 560mg/4 mL (140 mg/mL)	**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)	Initiation of Last Cycle Date: _____ Quantity Sufficient of vials (1 cycle) Number of refills (Treatment cycles) authorized: _____ *1 cycle = 6 weekly Infusions
	☐ 840mg/6mL (140 mg/mL)	**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

☐ 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: _____
Patient Address: _____
Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Vyvgart Hytrulo Vial	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 to 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
☐ Vyvgart Hytrulo Prefilled Syringe	1,000 mg efgartigimod alfa and 10,000 units hyaluronidase per 5mL	**Directions:** Administer 4 weekly injections (1,000 mg efgartigimod alfa and 10,000 units hyaluronidase per week) subcutaneously over 20 to 30 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 prefilled syringes (1 cycle) Number of refills (Treatment cycles) authorized: _____ *1 cycle = 4 weekly injections

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: _____

☐ 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.