

Vyvgart Enrollment Form



Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

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 #: _____ Address: _____

City, State, ZIP Code: _____ Group or Hospital: _____

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

G61.81 Chronic Inflammatory Demyelinating Polyneuropathy

Other Code: _____ Description: _____

Patient Clinical Information:

Patient to be administered:

Hospital/Clinic

CVS Specialty to coordinate skilled nursing to provide home infusion or medication via gravity per home care protocols and provide IV/port access care, flushing per protocol.

CVS Specialty to coordinate skilled nursing to provide home administration via subcutaneous injection. Patient may be taught to self-infuse subcutaneous prefilled syringe.

Other: _____

Is this a first dose? Yes No

If yes, where is the patient to be infused for the first dose? MD office with MDO staff Hospital/Clinic

Home by HC nurse Other: _____

Specialty Pharmacy to coordinate nursing for home care or subcutaneous teaching for subcutaneous prefilled syringe? Yes No

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Please Complete Patient and Prescriber 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
<input type="checkbox"/> Vyvgart (Intravenous)	400 mg/20 mL (20 mg/mL)	<input type="checkbox"/> Infuse IV 10 mg/kg (Dose = ____ mg) weekly for 4 weeks (1 cycle). Infuse over 1 hour. <input type="checkbox"/> Infuse ____ mg/kg (Dose = ____ mg) weekly for ____ weeks. (1 cycle) Infuse over ____ hour(s). In patients weighing 120 kg or more, the recommended dose is 1200 mg per infusion. According to the Package Insert: Administer subsequent treatment cycles based on clinical evaluation.	Initiation of Last Cycle Date: _____ Quantity Sufficient of vials (1 cycle) Number of refills (Treatment cycles) authorized: _____
<input type="checkbox"/> Vyvgart Hytrulo Vial (Subcutaneous)	1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL	gMG dosing: 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.	Initiation of Last Cycle Date: _____ Quantity Sufficient of vials (1 cycle) Number of refills (Treatment cycles) authorized: _____ *1 cycle = 4 weekly injections
<input type="checkbox"/> Vyvgart Hytrulo Vial (Subcutaneous)	1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL	CIDP dosing: Administer weekly injections (1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per week) subcutaneously over approximately 30-90 seconds.	Quantity _____ Number of refills authorized: _____

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: _____
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Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber. This form is not a valid prescription in Arizona.

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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Please Complete Patient and Prescriber 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
<input type="checkbox"/> Vyvgart Hytrufo Prefilled Syringe (Subcutaneous)	1,000 efgartigimod alfa And 10,000 units hyaluronidase per 5 mL	gMG dosing: Administer 4 weekly injections (1,000 mg efgartigimod alfa and 10,000 units hyaluronidase per week) subcutaneously over approximately 20 to 30 seconds. Administer subsequent treatment cycles according to clinical evaluation.	Initiation of Last Cycle Date: _____ Quantity Sufficient of vials (1 cycle) Number of refills (Treatment cycles) authorized: _____ *1 cycle = 4 weekly injections
<input type="checkbox"/> Vyvgart Hytrufo Prefilled Syringe (Subcutaneous)	1,000 efgartigimod alfa And 10,000 units hyaluronidase per 5 mL	CIDP dosing: Administer weekly injections (1,000 mg efgartigimod alfa and 10,000 units hyaluronidase per week) subcutaneously over approximately 20 to 30 seconds.	Quantity _____ Number of refills authorized: _____

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

Nursing Medications Complete items below, required for Home Infusion

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> 0.9% Sodium Chloride	N/A	Use 0.9% Sodium Chloride Injection, USP, as a diluent to make a total volume to be administered of 125 mL	Quantity Sufficient Refills: PRN
Catheter <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC	IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV – NS 5 mL PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10 mL sterile saline to access port a cath	Quantity Sufficient Refills: PRN
<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

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