Myasthenia Gravis Subcutaneous Enrollment Form

CVS specialty®

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. 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: _____

Myasthenia Gravis Subcutaneous Enrollment Form

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
☐ Rystiggo	280 mg/2 mL (140 mg/mL)	☐ **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 ☐ **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) ☐ **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) 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

Myasthenia Gravis Subcutaneous Enrollment Form

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

Nursing Medications

Complete items below, required for Home Infusion

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
☐ Epinephrine **nursing requires**	☐ IM ☐ 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.