Vyvgart 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 #: _____ 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

Vyvgart Enrollment Form

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
☐ Vyvgart (Intravenous)	400 mg/20 mL (20 mg/mL)	☐ Infuse IV 10 mg/kg (Dose = _____ mg) weekly for 4 weeks (1 cycle). Infuse over 1 hour. ☐ 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; 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:_____
☐ 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. 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 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: _____**
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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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
☐ Vyvgart Hytrulo 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. 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 (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: _____

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Nursing Medications Complete items below, required for Home Infusion

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
☐ 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 ☐ PIV ☐ PORT ☐ 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
☐ 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:_____

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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.
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