Enrollment Form for HCPs

VYVGART Hytrulo® (efgartigimod alfa and hyaluronidase-qvfc) | VYVGART® (efgartigimod alfa-fcab)

To enroll patients, **fax** the completed form to My VYVGART Path at **1-833-MY-V-PATH (1-833-698-7284)**. Office hours: Monday through Friday, 8 AM to 8 PM ET.

For questions, please contact My VYVGART Path at **1-833-MY-PATH-1 (1-833-697-2841)**.

Visit **MyPathEnroll.com** for more information.

*IMPORTANT

☐ My patient has **GENERALIZED MYASTHENIA GRAVIS (gMG)**—please complete pages 1, 2, 4 (if applicable), and 5.

☐ My patient has **CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP)**—please complete pages 1, 3, 4 (if applicable), and 5.

1. PATIENT INFORMATION

*Indicates required field.

***Patient First Name:**	Patient Middle Initial:	***Patient Last Name:**	
***DOB (MM/DD/YYYY):**	***Patient Email:**	***Phone #:**	Alternate Phone #:
***Patient Mailing Address:**		***City:**	***State:** / ***Zip:**

Patient Gender: ☐ Male ☐ Female ☐ Nonbinary

Patient-Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Is your patient new to VYVGART Hytrulo or VYVGART? ☐ Yes ☐ No

Authorized Caregiver or Alternate Contact: *By providing this information, you authorize My VYVGART Path to discuss the patient's health condition and participation in My VYVGART Path with the person named below.*

Caregiver First Name:	Caregiver Middle Initial:	Caregiver Last Name:
Relationship to Patient:	Caregiver Email:	Caregiver Phone #:

2. INSURANCE INFORMATION

Please fax copies of both the front and back of all medical and prescription insurance cards.

Check here if the patient has no insurance: ☐

Co-pay Program: ☐ Yes ☐ No

Patient Assistance Program: ☐ Yes ☐ No

	*Primary Benefit	Secondary Benefit	Pharmacy Benefit
***Insurance Name:**			
***Policyholder Name:**			
***Policy ID #:**			
Relationship to Patient:			
Insurance Provider Phone #:			
Group #:			
PCN #:			
BIN #:			

3. PRESCRIBER INFORMATION

***Prescriber Name (First, Middle, Last):**		***Practice Name:**	
***NPI #:**	***Tax ID:**	***State License #:**	Medicare/Medicaid Provider #:
***Practice Address:**		***City:**	***State:** / ***Zip:**
***Office Phone #:**	***Office Fax #:**	Prescriber Email:	

Please provide direct contact information for an office contact who can handle access issues.

Office Contact Name:	Office Contact Phone #:	Office Contact Email:

4. ■ *gMG PRESCRIPTION INFORMATION

*Patient First Name:	Patient Middle Initial:	*Patient Last Name:	*DOB (MM/DD/YYYY):

*Primary Diagnosis ICD-10 Code: ☐ G70.00 (Myasthenia gravis without acute exacerbation) ☐ G70.01 (Myasthenia gravis with acute exacerbation)

*Anti-AChR Antibody Positive: ☐ Yes ☐ No | Patient Allergies: ☐ No known allergies

Current Therapies: ☐ Treatment-naïve ☐ Mestinon ☐ Nonsteroidal ISTs ☐ Corticosteroids ☐ Zilucoplan ☐ Other _____
☐ Rituximab ☐ Eculizumab ☐ Rozanolixizumab ☐ Ravulizumab-cwvz ☐ IVIg/SCIg

Previous Therapies: ☐ Treatment-naïve ☐ Mestinon ☐ Nonsteroidal ISTs ☐ Corticosteroids ☐ Zilucoplan ☐ Other _____
☐ Rituximab ☐ Eculizumab ☐ Rozanolixizumab ☐ Ravulizumab-cwvz ☐ IVIg/SCIg
☐ VYVGART ☐ VYVGART Hytrulo

Current MG-ADL Score: _____
MG-ADL=Myasthenia Gravis Activities of Daily Living

MGFA Classification: _____
MGFA=Myasthenia Gravis Foundation of America

Please select treatment. Complete the applicable prescription information section(s) based on this selection.

☐ VYVGART (efgartigimod alfa-fcab) for intravenous use

VYVGART dosing is weight-based. For assistance, visit VYVGARTHCP.com/gMGDosing.

gMG DOSING:

10 mg/kg x patient weight (kg) = dose (mg)

Strength: 400 mg/20 mL (20 mg/mL) in a 20-mL single-dose vial

CALCULATED DOSE:

*Patient weight: _____ kg

To convert from lb to kg, divide the patient's weight in lb by 2.205. For patients weighing 120 kg or more, the dose should not exceed 1,200 mg (3 vials) per infusion.

☐ _____ mg based on weight ☐ 1,200 mg for patients greater than 120 kg

DIRECTIONS:

Infuse once weekly for 4 weeks (4 once-weekly infusions = 1 treatment cycle) with _____ weeks between infusion cycles

Additional instruction:

REFILLS:

*Number of refills authorized: _____

(4 once-weekly infusions = 1 treatment cycle)

PREFERRED SITE OF CARE:

☐ Prescriber's office **Buy and Bill:** ☐ Yes ☐ No
☐ Home infusion
☐ Infusion center
☐ Hospital outpatient
☐ Patient's choice
☐ Alternative site
☐ Specialty pharmacy

Other instruction:

☐ VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection

Prefilled syringe

VYVGART Hytrulo is a fixed dose per injection.

gMG DOSING:

1,000 mg efgartigimod alfa and 10,000 units hyaluronidase per 5.0 mL (200 mg/2,000 units per mL) in a single-dose prefilled syringe

DIRECTIONS:

Administer subcutaneously over approximately 20 to 30 seconds once weekly for 4 weeks (4 once-weekly injections = 1 treatment cycle) with _____ weeks between treatment cycles

Additional instruction:

DISPENSE QUANTITY:

☐ 1 pack = 4 prefilled syringes for a 28-day supply

REFILLS:

*Number of refills authorized: _____

(4 once-weekly injections = 1 treatment cycle)

PREFERRED SITE OF CARE:

☐ Home injection
☐ Prescriber's office
☐ Specialty pharmacy

Other instruction:

☐ VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection

Vial

VYVGART Hytrulo is a fixed dose per injection.

gMG DOSING:

1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL (180 mg/2,000 units per mL) in a single-dose vial

DIRECTIONS:

Administer subcutaneously over approximately 30 to 90 seconds once weekly for 4 weeks (4 once-weekly injections = 1 treatment cycle) with _____ weeks between treatment cycles

Additional instruction:

DISPENSE QUANTITY:

☐ 4 vials

REFILLS:

*Number of refills authorized: _____

(4 once-weekly injections = 1 treatment cycle)

PREFERRED SITE OF CARE:

☐ Prescriber's office **Buy and Bill:** ☐ Yes ☐ No
☐ Home injection
☐ Infusion center
☐ Hospital outpatient
☐ Patient's choice
☐ Alternative site
☐ Specialty pharmacy

Other instruction:

PRESCRIBER AUTHORIZATION AND ATTESTATION

By signing below, I certify that I am prescribing VYVGART Hytrulo or VYVGART for the patient identified herein, and that I have received permission from the patient and met other applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and applicable state laws needed to release the information that I am providing in this enrollment form. I understand that such information may be used by My VYVGART Path, its designated agents, service providers, and dispensing pharmacies for the purposes of verifying the patient's insurance coverage for VYVGART Hytrulo or VYVGART, confirming prior authorization requirements for VYVGART Hytrulo or VYVGART, if needed, on my patient's behalf, providing information to my office or the patient on appeals of denials of claims, coordinating delivery of VYVGART Hytrulo or VYVGART, and providing my patient with other education and support. I authorize My VYVGART Path, its affiliates, agents, and contractors to act on my behalf for the limited purposes of transmitting this prescription, by any means allowed under applicable law, to the appropriate pharmacy designated by the patient utilizing their benefit plan.

For the VYVGART Hytrulo prefilled syringe, the specialty pharmacy nurse will provide the patient with 2 self-injection trainings, including an assessment, subcutaneous administration, and education regarding medication preparation, VYVGART administration, and dosing. Additional trainings can be coordinated upon request. Needles, syringes, and ancillary supplies necessary for home administration will be provided.

ATTN: New York and Iowa providers, please submit an electronic prescription.

Dispense As Written/Brand Medically Necessary/Do Not Substitute/No Substitution/DAW/May Not Substitute

*Prescriber Signature: _____ *Date (MM/DD/YYYY): _____

4. ☐ *CIDP PRESCRIPTION INFORMATION

VYVGART Hytrulo only

*Patient First Name:	Patient Middle Initial:	*Patient Last Name:	*DOB (MM/DD/YYYY):

*Primary Diagnosis ICD-10 Code: ☐ G61.81 (Chronic inflammatory demyelinating polyneuritis)

Patient Allergies: ☐ No known allergies

Current Therapies: ☐ Treatment-naïve ☐ IVIg/SCIg ☐ Corticosteroids ☐ Other _____

Previous Therapies: ☐ Treatment-naïve ☐ IVIg/SCIg ☐ Corticosteroids ☐ Other _____ ☐ VYVGART Hytrulo

	CIDP DOSING:	DIRECTIONS:	DISPENSE QUANTITY:	REFILLS:	PREFERRED SITE OF CARE:
☐ **VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection** **Prefilled syringe** VYVGART Hytrulo is a fixed dose per injection.	**1,000 mg efgartigimod alfa and 10,000 units hyaluronidase per 5.0 mL (200 mg/2,000 units per mL) in a single-dose prefilled syringe**	Administer subcutaneously over approximately 20 to 30 seconds once weekly ➔ Additional instruction:	☐ 1 pack = 4 prefilled syringes for a 28-day supply	*Number of refills authorized: _____	☐ Home injection ☐ Prescriber's office ☐ Specialty pharmacy _____ ➔ Other instruction:
☐ **VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection** **Vial** VYVGART Hytrulo is a fixed dose per injection.	**1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL (180 mg/2,000 units per mL) in a single-dose vial**	Administer subcutaneously over approximately 30 to 90 seconds once weekly ➔ Additional instruction:	☐ 4 vials	*Number of refills authorized: _____	☐ Prescriber's office **Buy and Bill:** ☐ Yes ☐ No ☐ Home injection ☐ Infusion center ☐ Hospital outpatient ☐ Patient's choice ☐ Alternative site ☐ Specialty pharmacy _____ ➔ Other instruction:

PRESCRIBER AUTHORIZATION AND ATTESTATION

By signing below, I certify that I am prescribing VYVGART Hytrulo for the patient identified herein, and that I have received permission from the patient and met other applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and applicable state laws needed to release the information that I am providing in this enrollment form. I understand that such information may be used by My VYVGART Path, its designated agents, service providers, and dispensing pharmacies for the purposes of verifying the patient's insurance coverage for VYVGART Hytrulo, confirming prior authorization requirements for VYVGART Hytrulo, if needed, on my patient's behalf, providing information to my office or the patient on appeals of denials of claims, coordinating delivery of VYVGART Hytrulo, and providing my patient with other education and support. I authorize My VYVGART Path, its affiliates, agents, and contractors to act on my behalf for the limited purposes of transmitting this prescription, by any means allowed under applicable law, to the appropriate pharmacy designated by the patient utilizing their benefit plan.

For the VYVGART Hytrulo prefilled syringe, the specialty pharmacy nurse will provide the patient with 2 self-injection trainings, including an assessment, subcutaneous administration, and education regarding medication preparation, VYVGART administration, and dosing. Additional trainings can be coordinated upon request. Needles, syringes, and ancillary supplies necessary for home administration will be provided.

ATTN: New York and Iowa providers, please submit an electronic prescription.

Dispense As Written/Brand Medically Necessary/Do Not Substitute/No Substitution/DAW/May Not Substitute

*Prescriber Signature: _____ *Date (MM/DD/YYYY): _____

↓ QUICK START PROGRAM ↓

5. VYVGART HYTRULO QUICK START PROGRAM

» **OPTIONAL:** Complete this page if you are requesting a Quick Start shipment for your patient. The VYVGART Hytrulo Quick Start Program provides a limited supply of medication at no charge to **eligible patients with commercial insurance only**. Eligible patients must be starting VYVGART Hytrulo for the first time and should not have previously received VYVGART for IV infusion.

*Patient First Name:	Patient Middle Initial:	*Patient Last Name:	*DOB (MM/DD/YYYY):

*Place of Administration/Ship to:
- ☐ Prescriber's office
- ☐ Patient's home

gMG PRESCRIPTION INFORMATION

☐ **VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection** **Prefilled syringe** VYVGART Hytrulo is a fixed dose per injection.	**gMG DOSING:** **1,000 mg efgartigimod alfa and 10,000 units hyaluronidase per 5.0 mL (200 mg/2,000 units per mL) in a single-dose prefilled syringe** **Number of refills (treatment cycles) authorized: 2 refills** (4 once-weekly injections = 1 treatment cycle)	**DIRECTIONS:** Administer subcutaneously over approximately 20 to 30 seconds once weekly for 4 weeks (4 once-weekly injections = 1 treatment cycle) with 4 weeks between treatment cycles	**ADDITIONAL INSTRUCTIONS**
☐ **VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection** **Vial** VYVGART Hytrulo is a fixed dose per injection.	**gMG DOSING:** **1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL (180 mg/2,000 units per mL) in a single-dose vial** **Number of refills (treatment cycles) authorized: 2 refills** (4 once-weekly injections = 1 treatment cycle)	**DIRECTIONS:** Administer subcutaneously over approximately 30 to 90 seconds once weekly for 4 weeks (4 once-weekly injections = 1 treatment cycle) with 4 weeks between treatment cycles	**ADDITIONAL INSTRUCTIONS**

CIDP PRESCRIPTION INFORMATION

☐ **VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection** **Prefilled syringe** VYVGART Hytrulo is a fixed dose per injection.	**CIDP DOSING:** **1,000 mg efgartigimod alfa and 10,000 units hyaluronidase per 5.0 mL (200 mg/2,000 units per mL) in a single-dose prefilled syringe** **Dispense quantity: 4** (Dispensed as single-dose syringes) **Refills: 5 refills**	**DIRECTIONS:** Administer subcutaneously over approximately 20 to 30 seconds once weekly	**ADDITIONAL INSTRUCTIONS**
☐ **VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection** **Vial** VYVGART Hytrulo is a fixed dose per injection.	**CIDP DOSING:** **1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL (180 mg/2,000 units per mL) in a single-dose vial** **Dispense quantity: 4** (Dispensed as single-dose vials) **Refills: 5 refills**	**DIRECTIONS:** Administer subcutaneously over approximately 30 to 90 seconds once weekly	**ADDITIONAL INSTRUCTIONS**

*PRESCRIBER INFORMATION

*Prescriber Name (First, Middle, Last):	*NPI #:	*State License #:	
*Practice Address:	*City:	*State:	*Zip:
*Office Phone #:	*Office Fax #:		

PRESCRIBER AUTHORIZATION AND ATTESTATION

The VYVGART Hytrulo Quick Start Program supplies medication to eligible commercial patients with a confirmed coverage delay of 5 calendar days. Eligible patients must have commercial insurance and be starting VYVGART Hytrulo for the first time. The program can provide up to 3 shipments for gMG and 6 shipments for CIDP.

I understand that the medication provided is complimentary and that no claim may be made to any patient or third-party payer (e.g., Medicare, Medicaid, and or commercial insurance) for payment for VYVGART Hytrulo provided under the Quick Start Program and that such product cannot be sold, traded, or returned for credit. argenx reserves the right to rescind, revoke, or amend this program without notice at any time.

When home location is selected, a healthcare provider is to administer VYVGART Hytrulo subcutaneously or train on self-administration when the VYVGART Hytrulo prefilled syringe is selected. My signature on the form indicates that this injection requires home infusion services by a specialty pharmacy–associated provider.

*Prescriber Signature: _____ *Date (MM/DD/YYYY): _____

6. PATIENT AUTHORIZATION TO COLLECT, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION (Required for enrollment into the My VYVGART Path Patient Support Program)

By signing below, I authorize my healthcare providers, pharmacies, and health plans (collectively, my "Health Team") to: disclose my personal health information ("PHI"), including my medical condition, prescription, and insurance coverage, to argenx, its affiliates, contractors, and agents, in order for them to use and share with my Health Team as needed to enroll me in My VYVGART Path; conduct benefits investigations and take related actions to determine my eligibility for, and coordinate financial assistance for me to receive VYVGART Hytrulo or VYVGART; communicate with my Health Team about my treatment plan; provide me with support services, including disease state and VYVGART Hytrulo or VYVGART education and resources; help facilitate prescription and refill fulfillment; facilitate quality control and related reporting activities; use my de-identified data for research and publication; conduct data analytics, market research, and My VYVGART Path–related business activities; and/or contact me about My VYVGART Path services. I understand that once my PHI has been disclosed to argenx, it may no longer be protected by federal privacy law and could be re-disclosed to others; I can withdraw this authorization by calling 833-697-2841 or mailing notice of revocation to My VYVGART Path, 680 Century Point, Suite 1000, Lake Mary, FL 32746; revocation will take effect when My VYVGART Path receives my notice of revocation, but uses and disclosures made in reliance on the authorization prior to its revocation will not be invalidated; my healthcare treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my signing this authorization; this authorization expires 10 years after signing or on such earlier date as state law may require and I am entitled to receive a copy of this authorization after I sign it. A disclosing party may receive remuneration in exchange for PHI if our relationship involves receipt of compensation in exchange for data or in connection with providing PHI pursuant to an authorization. I understand that I am entitled to submit a written request to argenx for a copy of this consent language, along with any disclosed PHI. I further authorize argenx to contact any individual(s) identified as an Authorized Caregiver (below) to discuss my medical condition or my participation in My VYVGART Path, and I understand that such discussions may require argenx to disclose my PHI to such Authorized Caregiver.

***Patient Name:**	***DOB (MM/DD/YYYY):**
***Patient Signature:**	***Date Signed (MM/DD/YYYY):**
Caregiver Name and Signature:	

☐ *Check here to receive patient education program information, engagement communication requests from argenx, and emails promoting argenx products and services.*

☐ *Check here to consent to mobile messaging promoting argenx products and services. Message and data rates may apply.*

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