My VYVGART® Path

# Enrollment form

VYVGART® (efgartigimod alfa-fcab) Injection for Intravenous Use 400 mg/20 mL vial

VYVGART® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) Subcutaneous Injection 180 mg/mL and 2000 U/mL vial

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

*Required field

## 1. Patient Information

| | |
|---|---|
| ***Patient First Name:** | ***Patient Last Name:** |
| ***DOB (MM/DD/YYYY):** | Gender: ☐ Male ☐ Female ☐ Non-Binary |
| *Patient Mailing Address: | |

| | | |
|---|---|---|
| *City: | *State: | *Zip: |
| Preferred Language: ☐ English ☐ Spanish ☐ Other _____ | *Phone #: | |
| *Patient Email: | Is your patient new to VYVGART? ☐ Yes ☐ No | |

## 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: ☐

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

## 3. Prescriber Information

| | | | |
|---|---|---|---|
| *Prescriber Name (First, Middle, Last): | | *Practice Name: | |
| *NPI #: | *Tax ID: | Medicare/Medicaid Provider #: | *State License #: |
| *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. Prescription Information

| *Patient First Name: | *Patient Last Name: | *DOB (MM/DD/YYYY): |
|---|---|---|
| | | |

| *Primary Diagnosis ICD-10 Code: | *Anti-AChR antibody positive: | Allergies: |
|---|---|---|
| ☐ G70.00 ☐ G70.01 | ☐ Yes ☐ No | |

*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*

**Please check only 1 box below for preferred VYVGART treatment. Complete the applicable prescription information section(s) based on this selection.**
**If you select the third option, please fill out both sections for VYVGART and VYVGART Hytrulo.**

☐ Intravenous: VYVGART (efgartigimod alfa-fcab)

☐ Subcutaneous injection: VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)

☐ Intravenous **or** subcutaneous injection: VYVGART (efgartigimod alfa-fcab) **or** VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)

| **VYVGART (efgartigimod alfa-fcab) for intravenous use**<br>**Dose:** VYVGART is weight based. For assistance, visit VYVGARTdose.com. | **VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection**<br>**Dose:** VYVGART Hytrulo is a fixed dose per injection. |
|---|---|
| *Dose: _____ mg<br>• *10 mg/kg x patient weight (kg) = dose (mg)*<br>• *Strength: 400 mg/20 mL (20 mg/mL) in a 20 mL single-dose vial*<br>Dose Cadence:<br>*4 weekly infusions every _____ weeks<br>*Number of Refills (treatment cycles) Authorized: _____<br>*4 once weekly infusions equal 1 treatment cycle.* | Dose: 5.6 mL efgartigimod 1,008 mg/hyaluronidase 11,200 units<br>Dose Cadence:<br>*4 weekly injections every _____ weeks<br>*Number of Refills (treatment cycles) Authorized: _____<br>*4 once weekly injections equal 1 treatment cycle.* |
| *Infusion Location:<br>☐ Prescribing Physician's Office ☐ Home Infusion ☐ Infusion Center<br>☐ Hospital Outpatient ☐ Patient Choice ☐ Specialty Pharmacy | * Injection Location:<br>☐ Prescribing Physician's Office ☐ Home Injection ☐ Infusion Center<br>☐ Hospital Outpatient ☐ Patient Choice ☐ Specialty Pharmacy |
| *Buy and Bill: ☐ Yes ☐ No | *Buy and Bill: ☐ Yes ☐ No |
| Supplies:<br>☐ Dispense needles, syringes, and ancillary supplies necessary for home administration. | Supplies:<br>☐ Dispense needles, syringes, and ancillary supplies necessary for home administration. |
| **Nurse Administration**<br>Provide skilled nurse administration of medication as prescribed and assess general status. | **Nurse Administration:**<br>Provide skilled nurse administration of medication as prescribed and assess general status. |
| Preferred Infusion Site Name: | Preferred Injection Site Name: |
| Preferred Infusion Site Address: | Preferred Injection Site Address: |
| Preferred Specialty Pharmacy Name: | Preferred Specialty Pharmacy Name: |
| Other Instructions: | Other Instructions: |

**Prescriber Authorization and Attestation**
By signing below, I certify that I am prescribing 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, confirming prior authorization requirements for 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, and providing my patient with other education and support.

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

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

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

## 5. PATIENT AUTHORIZATION TO COLLECT, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION

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; communicate with my Health Team about my treatment plan; provide me with support services including disease state and 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):** |

**Authorized Caregiver Name and Phone Number:**

☐ ***Check here to receive patient educational program information, engagement communications 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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