Please fax all pages of completed form to your team at 866.233.7151.
To reach your team, call toll-free 866.820.4844.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

Vyvgart® and Vyvgart Hytrulo®

EVERNORTH HEALTH SERVICES

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

Insurance company _____ Phone _____

Insured's name _____ Insured's employer _____

Relationship to patient _____ Identification # _____ Policy/group # _____

Prescription card: ☐ Yes ☐ No If yes, carrier _____ Policy # _____ Group #: _____

Is patient eligible for Medicare? ☐ Yes ☐ No Does patient have secondary insurance? ☐ Yes ☐ No

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office address _____

Office contact and title _____

Office contact phone number _____ Office contact email _____

Office/clinic/institution name _____ Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

Infusion location: ☐ Patient's home ☐ Office ☐ Infusion clinic Infusion clinic address: _____

Infusion clinic contact _____ Phone _____ Email address _____

3 Clinical Information

CHECK ONE

ICD-10 code (REQUIRED): ☐ G70.00 Myasthenia gravis without (acute) exacerbation ☐ G70.01: Myasthenia gravis with (acute) exacerbation ☐ G61.81 Chronic inflammatory demyelinating polyneuritis (CIDP) ☐ **Other** _____

gMG Type: ☐ AChR Antibody Positive ☐ MuSK Antibody Positive ☐ Triple Seronegative ☐ LRP4 Antibody Positive

MG-ADL* score (if known) _____ Date score obtained _____

Is your patient new to therapy? ☐ Yes ☐ No Other drugs used to treat the disease _____

*Myasthenia Gravis Activities of Daily Life

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

3 Clinical Information (cont.)

Weight _____ kg/lbs Height _____ cm/in Date recorded _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Adverse reactions with previous MG treatments? _____

If so, what MG treatment caused the reaction? _____

4 Prescribing Information

Medication	Route	Strength/Formulation	Directions
☐ Vyvgart® vial	IV	400mg/20mL single-dose vial infusion	Infuse _____ mg/kg OR _____ mg intravenously over one hour. Initial treatment cycle: 1 time weekly for 4 weeks, rounding to an easily measurable dose when clinically appropriate. Administer additional treatment cycle _____ weeks between cycles counted from the last dose of the previous treatment cycle to the first dose of the next and then repeat cycles moving forward. OR ☐ Prescriber to evaluate treatment cycle frequency after completion of initial treatment cycle. Additional prescription will be required. **Vascular access:** ☐ Peripheral ☐ Central ☐ Port **Infusion method:** ☐ Gravity ☐ Pump
☐ Vyvgart Hytrulo® vial	SQ injection	1,008mg efgartigimod alfa/11,200 hyaluronidase units per 5.6mL single-dose vial injection	Administer 1,008mg subcutaneously over 30 to 90 seconds. Vyvgart Hytrulo must only be administered by a healthcare professional. **For CIDP diagnosis:** Frequency: once weekly ongoing. **For gMG diagnosis:** Frequency: Initial Treatment cycle: 1 time weekly for 4 weeks. Administer additional treatment cycle _____ weeks between cycles counted from the last dose of the previous treatment cycle to the first dose of the next and then repeat cycles moving forward. OR ☐ Prescriber to evaluate treatment cycle frequency after completion of initial treatment cycle. Additional prescription will be required.
☐ Vyvgart Hytrulo® prefilled syringe	SQ injection	1000mg efgartigimod alfa/10,000 hyaluronidase units per 5mL prefilled syringe	Administer 1000mg subcutaneously over 20 to 30 seconds. Vyvgart Hytrulo prefilled syringe may be administered by patients and/or caregivers after proper instruction in subcutaneous injection technique. **For CIDP diagnosis:** Frequency: once weekly ongoing. **For gMG diagnosis:** Frequency: Initial Treatment cycle: 1 time weekly for 4 weeks. Administer additional treatment cycle _____ weeks between cycles counted from the last dose of the previous treatment cycle to the first dose of the next and then repeat cycles moving forward. OR ☐ Prescriber to evaluate treatment cycle frequency after completion of initial treatment cycle. Additional prescription will be required.
☐ Other instructions _____			

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ _____ _____ _____

Date **Dispense as written** **Date** **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information (cont.)

Medication	Route	Strength/Formulation	Directions

Adverse reaction medications: *(for Vyvgart IV only- keep on hand at all times)*

- Epinephrine 0.3mg auto-injector 2-pk for patients weighing greater than or equal to 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose
- Epinephrine 0.15mg auto-injector 2-pk for patients weighing less than 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose
- Diphenhydramine 25mg by mouth for mild allergic reactions and 50mg for moderate to severe times one dose

Flushing orders: *(for Vyvgart IV only)*

- 0.9% Normal Saline 3mL intravenous (peripheral line) or 10mL intravenous (central line) before and after infusion, or as needed for line patency
- Heparin 10 units per mL 3mL intravenous (peripheral line maintained >1 day) as needed for final flush
- Heparin 100 units per mL 5mL intravenous (central line) as needed for final flush
- May flush with 20mL Normal Saline post infusion to clear drug from line

Supplies: *(please strike through if not required)*
Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

Quantity/Refills: Dispense 1 treatment cycle supply or 1-month supply. Refill x 1 year unless noted otherwise.
☐ Additional refills to be provided upon patient reassessment.
☐ Other _____

Skilled nursing: Vyvgart IV and Vyvgart Hytrulo vials Visit as needed to establish venous access, administer medication and assess general status and response to therapy. Vyvgart Hytrulo prefilled syringe- Skilled nursing visits to educate patient on subcutaneous access, medication administration, use of supplies, therapy and disease state and to assess general status and response to therapy. Nurse to establish access to administer during training if needed. Patient to be discharged from nursing once teaching complete.

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ **Date** _____ **Dispense as written** _____ **Date** _____ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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Prior Authorization Checklist

Myasthenia Gravis (MG)

Providing Accredo, Evernorth's specialty pharmacy, with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients.[1] Coverage criteria may vary by payer.

Enrollment form
(not required for electronic prescriptions)

- ☐ **Completed** myasthenia gravis enrollment form (available at accredo.com)
- ☐ **Copies of front and back** of medical insurance and prescription benefit cards

Clinical documents

- ☐ **History and Physical (H&P)** and progress notes (within past 6 months)[2]
  Note: Diagnosis of the disorder must be unequivocal

Fax completed form to 866.233.7151.

If you have any questions, please call your Accredo Provider Support Advocate, or call 866.820.4844.

Myasthenia Gravis (MG)

- ☐ **Tensilon** test results
- ☐ **Tried and failed medications**, or has contraindication to immunosuppressant therapies (e.g., Mestinon®/ corticosteroids/azathioprine/ cyclosporine/mycophenolate)
- ☐ **Ongoing immunoglobulin (Ig) treatment** must be documented in H&P and progress notes[2]
- ☐ **Myasthenic Panel** (MG Testing)
- ☐ **History and Physical** (H&P) and progress notes presenting acute myasthenic crisis and decompensation (respiratory failure or disabling weakness). Include Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL)
- ☐ **Clinical assessment** that indicates eye muscle weakness, ptosis or swallowing issues
- ☐ **Medication is prescribed by** or in consultation with a neurologist

[1]This myasthenia gravis checklist is based on Medicare Part D guidelines and evidence of disease symptoms related to myasthenia gravis.

[2]Ongoing management and documentation requirements:
a. Initial improvement and continued need must be meticulously documented in progress notes
b. All weaning must be attempted and documented as either amount or frequency

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