Please fax both pages of completed form to your drug therapy 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.

Prescription & Enrollment Form

Vyvgart® (efgartigimod)

accredo®

Four simple steps to submit your referral.

☐ Do not contact patient, benefits check only

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 _____

☐ Male ☐ Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

☐ 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 _____ Identifcation # _____ 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

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 e-mail _____

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 _____ E-mail address _____

3 Clinical Information

CHECK ONE

ICD-10 code (REQUIRED): ☐ G70.00 Myasthenia gravis without (acute) exacerbation ☐ G70.01: Myasthenia gravis with (acute) exacerbation

☐ **Other** _____

MG-ADL* score (if known) _____

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

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? _____

*Myasthenia Gravis Activities of Daily Life

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

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Dose	Directions
Vyvgart	400mg/20mL vial injection	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 cycles every _____ weeks OR ☐ Prescriber to evaluate treatment cycle frequency after completion of initial treatment cycle. *Additional prescription will be required* Round to an easily measurable dose when clinically appropriate.	**Vascular access:** ☐ Peripheral ☐ Central ☐ Port **Infusion method:** ☐ Gravity ☐ Pump

☐ Other instructions _____

Adverse reaction medications: *(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

For pediatric patients, the following weight- and age-based dosing range will be used:
<9kg and/or <2 years old: Diphenhydramine 1mg/kg up to max of 6.25mg times one dose
2–5 years old and >9kg: Diphenhydramine 6.25mg to 12.5mg times one dose
6–12 years old: Diphenhydramine 12.5 to 25mg times one dose

Flushing orders:
- 0.9% Normal Saline 3mL intravenous (peripheral line maintained >1 day) 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. Refill x 1 year unless noted otherwise.

☐ Additional refills to be provided upon patient reassessment.

☐ Other _____

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.

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

Providing Accredo 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.

Referral Form (not required for electronic prescriptions)	
	Completed myasthenia gravis referral form (available at accredo.com)
	Copies of front and back of all 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
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

Fax completed form to 866.233.7151.

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

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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