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 #:
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	

*Number of Refills (Treatment Cycles) Authorized:	*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 select only one preferred method of administration for VYVGART. 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) and VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)

VYVGART (efgartigimod alfa-fcab) for intravenous use

4 once-weekly infusions equal one treatment cycle.

Dosing for VYVGART is weight-based. Using the information below, calculate the dose (mg), total drug volume (mL) of VYVGART solution required, and the number of vials needed based on the recommended dose, according to the patient's body weight. Each vial contains a total of 400 mg of VYVGART at a concentration of 20 mg per mL. For assistance, visit VYVGARTdose.com or utilize the sample calculations.

*Dose _____mg

- *10 mg/kg x patient weight (kg) = dose (mg)*
- *Strength: 400 mg/20 mL (20 mg/mL) in a 20 mL single-dose vial*

*Drug Volume _____mL

Dose (mg) ÷ 20 mg/mL = drug volume (mL)

*Infusion Location:

☐ Prescribing Physician's Office ☐ Home Infusion ☐ Infusion Center ☐ Hospital Outpatient ☐ Patient Choice ☐ Specialty Pharmacy

*Buy and Bill: ☐ Yes ☐ No

Supplies:

☐ Dispense needles, syringes, ancillary supplies necessary for home administration

Nurse Administration:
Provide skilled nurse administration of medication as prescribed and assess general status.

Preferred Infusion Site Name:

Preferred Infusion Site Address:

Preferred Specialty Pharmacy Name:

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

Dose: VYVGART Hytrulo (5.6 mL efgartigimod 1,000 mg/hyaluronidase 11,200 units) subcutaneous once weekly for 4 weeks

4 once-weekly injections equal one treatment cycle.

Nursing Orders

Nurse training:
For the subcutaneous injection product, prior to the first injection, a specialty pharmacy nurse will provide the patient with mandatory self-injection training, including an assessment, subcutaneous administration, and education regarding medication preparation, VYVGART Hytrulo administration, and dosing. Please select the preferred training location below. Additional trainings can be coordinated upon request.

* Administration Location:

☐ Home ☐ Healthcare Provider Office ☐ Alternative Site

*Buy and Bill: ☐ Yes ☐ No

Supplies:

☐ Dispense needles, syringes, ancillary supplies necessary for home administration

Nurse Administration:
If the patient is unable to self-administer the subcutaneous injection product during injection training, a specialty pharmacy nurse can administer the subcutaneous injection.

Preferred Specialty Pharmacy Name:

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 My VYVGART Path at 1-833-MY-PATH-1 (1-833-697-2841) or mailing a letter with my notice of revocation to My VYVGART Path, 680 Century Point, Suite 1000, Lake Mary, FL 32746; if I do revoke the authorization, it will become invalid 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 the date I sign it below or on such earlier date as applicable 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 protected health information in the event our relationship involves receipt of compensation in exchange for data or in connection with providing protected health information 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 protected health information.

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

If signed by someone other than the patient, describe legal authority to do so:

☐ 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.

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

Phone: **1-833-MY-PATH-1** (1-833-697-2841)

argenx