# VYVGART (EFGARTIGIMOD ALFA) ORDER SET

**P:** 331-236-0610 | **F:** 331-314-8989

## PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

| | | | | | |
|---|---|---|---|---|---|
| Name: | | DOB: | | Gender: □ Female □ Male | |
| Address: | | City: | State: | ZIP: | |
| Phone: | Email: | Height: | □ inches □ cm | Weight: | □lbs. □ kg |
| Allergies: | | | | | |
| **Diagnosis Code ICD-10 (required):** | | **Diagnosis Description:** | | | |
| Patient Status: □ New to Therapy □ Continuing Therapy | | Next Treatment Date: | | | |

## PHYSICIAN INFORMATION

| | | | | |
|---|---|---|---|---|
| Prescriber Name: | | Phone: | Fax: | |
| Office Contact: | | | Email: | |
| Address: | | City: | State: | ZIP: |
| NPI #: | DEA#: | | Tax ID: | |

## INSURANCE INFORMATION (or attach copy of cards)

| | | |
|---|---|---|
| Primary Insurance: | Policy #: | Group #: |
| Secondary Insurance: | Policy #: | Group #: |

## PRESCRIPTION INFORMATION (or attach a copy of the prescription)

| Drug | Dosing | Frequency | Refills |
|---|---|---|---|
| **Vyvgart** (efgartigimod alfa) | □ 0mg/kg IV<br>□ 1200mg IV | □ Weekly for 4 weeks<br>□ Other: _____ | □ None<br>□ Repeat for _____ cycle(s), cycles to have _____ weeks between infusion cycles (4 weekly infusions= 1 treatment cycle)<br>□ _____ |
| **Vyvgart Hytrulo** (efgartigimod alfa/ hyaluronidase) | □ 1,008mg / 11,200 units SubQ | □ Weekly for 4 weeks<br>□ Weekly<br>□ Other: _____ | □ None<br>□ Repeat for _____ cycle(s), cycles to have _____ weeks between infusion cycles (4 weekly infusions = 1 treatment cycle)<br>□ x1 year<br>□ _____ |

Other orders: _____

Lab Orders: _____ Frequency: _____
Required labs to be drawn by: □ LIVbetter □ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

## PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

**Prescriber Signature: X** **Date:**

# COMPREHENSIVE SUPPORT FOR VYVGART (EFGARTIGIMOD ALFA) THERAPY

## PATIENT INFORMATION

Name: DOB:

## REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

□ Include signed and completed order (MD/prescriber to complete page 1)

□ Include patient demographic information and insurance information

□ Include patient's current medication list

□ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

□Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., pyridostigmine, immunosuppressants, corticosteroids, or acetylcholinesterase inhibitors)? □ Yes □ No

If yes, which drug(s)? _____

□Has the patient required 2 or more courses of plasmapheresis/plasma exchanges and/or intravenous immune globulin for at least 12 months without symptom control? □ Yes □ No

□Myasthenia Gravis Activities of Daily Living (MG-ADL) Score: _____

□gMG Classification (if applicable): □ II □ III □ IV

□Does patient have a history of abnormal neuromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation? □ Yes □ No

□ Does the patient have a history of positive anticholinesterase test? □ Yes □ No

□ Include labs and/or test results to support diagnosis

□ If ordering a subsequent treatment cycle, and patient is new to LIVbetter, please indicate the start date of the last completed cycle _____

□Other medical necessity: _____