BARNES HEALTHCARE SERVICES

Vygart & Vyvgart Hytrulo ® Order Form

Please fax all pages of completed form to our Intake team at 888.276.7948
Contact our Intake team 800.422.5059 ext.1480

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** _____ **MI** _____
Preferred patient first name _____ **Preferred patient last name** _____
Sex at birth: ☐ Male ☐ Female **Gender identity** _____ **Pronouns** _____
Last 4 of SSN _____ **Date of birth** _____/_____/_____
Street address _____ **Apt #** _____
City _____ **State** _____ **Zip** _____
Home phone _____ **Cell phone** _____ **Email address** _____
Parent/guardian (if applicable) _____
Home phone _____ **Cell phone** _____ **Email address** _____
Alternate caregiver/contact _____
Home phone _____ **Cell phone** _____ **Email 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** _____
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 Barnes Healthcare Services 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.

Date _____ **Time** _____ **Date medication needed** _____/_____/_____
Office/clinic/institution name _____
Prescriber's first name _____ **Last name** _____
Prescriber's title _____ **If NP or PA, under direction of Dr.** _____
Office phone _____ **Fax** _____ **NPI #** _____ **License #** _____
Office contact and title _____ **Office contact email** _____
Office street address _____ **Suite #** _____
City _____ **State** _____ **Zip** _____
Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site

If infusion site, complete information below:

Infusion site name _____ **Clinic/hospital affiliation** _____
Site street address _____ **Suite #** _____
City _____ **State** _____ **Zip** _____
Infusion site contact _____ **Phone** _____ **Fax** _____
Email _____

Note: Check the appropriate shipment options in Section 4: Prescribing Information.

3 Clinical Information

Primary ICD-10 code (REQUIRED):

☐ Myasthenia gravis without (acute) exacerbation: G70.0

☐ Myasthenia gravis with (acute) exacerbation: G70.01

☐ Chronic Inflammatory Demyelinating Polyneuritis (CIDP): G61.81

☐ Other:_____

HMG-ADL* Score if known: _____

Has the patient been treated previously for this condition? ☐ Yes ☐ No

Is patient currently on therapy? ☐ Yes ☐ No

Any adverse reactions with previous MG Treatments: ☐ Yes ☐ No

If Yes, what MG treatment caused the reaction,_____

Please list all therapies tried/failed: _____

Patient wt _____ **Date wt obtained:** _____/_____/_____

☐ NKDA **Known drug allergies** _____

Concurrent meds: _____

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 infusion cycles and then repeat cycle 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. Additional treatment cycle _____ weeks between infusion cycles and then repeat cycle 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. Additional treatment cycle _____ weeks between infusion cycles and then repeat cycle moving forward. OR Prescriber to evaluate treatment cycle frequency after completion of initial treatment cycle. Additional prescription will be required.
Other instructions			

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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.**(S9359, S9379)**
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.

On going lab orders CBC before each cycle (cycle = weekly x 4 doses)

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.

5. Prior Authorization Checklist: Primary Immune Deficiency Disease (PIDD)

Providing Barnes Healthcare with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients with PIDD. Coverage criteria may vary by payer.

Enrollment form (not required for electronic prescriptions)	
	Completed myasthenia gravis enrollment form (available at accredo.com)
	Copies of the front and back of all medical insurance and prescription benefits 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 notes2
	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