My VYVGART™ Path Enrollment Form

VYVGART® (efgartigimod alfa-fcab)
Injection for Intravenous Use
400 mg/20 mL vial

To enroll, fax 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: | Apt #:

*City: | *State: | *Zip:

*Preferred Language: ☐ English ☐ Spanish ☐ Other

*Preferred Phone #: | Secondary Phone #:

Ok to leave voice message? ☐ Yes ☐ No

Patient Email:

Authorized Caregiver or Alternate Contact
By providing this information, you authorize My VYVGART Path to discuss your health condition and participation in My VYVGART Path with the person named below.

Relationship to Patient: | Alt. Contact Phone #:

Alt. Contact Email:

2. Insurance Information

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

*Primary Benefit Insurance Name: | *Cardholder Name:

DOB (MM/DD/YYYY): | Relationship to Patient:

Phone #: | *Policy ID #: | Group #:

PCN #: | BIN #:

Secondary Benefit Insurance Name: | Cardholder Name:

DOB (MM/DD/YYYY): | Relationship to Patient:

Phone #: | Policy ID #: | Group #:

PCN #: | BIN #:

Check here if patient has no insurance ☐

3. Prescriber Information

*Prescriber Name (First, Middle, Last):

*Practice Name: | *NPI #:

Medicare/Medicaid Provider #: | *State License #:

*Street Address: | Suite #:

*City: | *State: | *Zip:

*Office Phone #: | *Office Fax #:

Prescriber Email:

Office Contact Name: | Office Contact Phone #:

Office Contact Email:

Office Preferred Method of Contact:

4. Prescription Information

*Patient First Name: | *Patient Last Name: | Suffix:

*Anti-AChR antibody positive: ☐

*Primary Diagnosis: ICD-10 Code: ☐ G70.00 ☐ G70.01
Product: VYVGART (efgartigimod alfa-fcab) injection for intravenous use

*Dose: | *Patient Weight (kg):

Strength: 400 mg/20 mL (20 mg/mL) in a 20 mL single-dose vial
*Quantity/Vials: | *Number of Refills Authorized:

Other Instructions:

*Is your patient new to this therapy? ☐ Yes ☐ No

Medication Allergies:

Concurrent Medications:

Previous Therapies:
☐ eculizumab ☐ rituximab ☐ IVIG ☐ oral corticosteroids ☐ nonsteroidal ISTs

*Prescriber Signature: | *Date (MM/DD/YYYY):

Dispense as written. No stamps.

5. Site of Care Information

*Infusion Location:
☐ Prescribing Physician's Office ☐ Home Infusion ☐ Infusion Center
☐ Hospital Outpatient ☐ Specialty Pharmacy _____

*Preferred Infusion Site Name and Address

6. Prescriber Authorization and Attestation

Required for prescription order and enrollment

I verify that the patient and healthcare provider information on this enrollment form was completed by me or at my direct order. After discussing My VYVGART Path (including its agents, service providers, and VYVGART dispensing pharmacies) with the patient, the patient has elected to participate in My VYVGART Path. The information contained herein is complete and accurate to the best of my knowledge. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to me by the dispensing pharmacy.

By signing below I certify that:

1. I am prescribing VYVGART for the patient identified in Section 1 (one) above. This prescription is medically necessary for the patient, and I have instructed the patient on the appropriate use and administration of VYVGART. I will be supervising the patient's treatment.
2. I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and applicable state laws needed to release the information that I have provided in completing this enrollment form and sending it to the argenx US, Inc. My VYVGART Path, and 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 available through My VYVGART Path associated with VYVGART.
3. I authorize the argenx third-party reimbursement support vendor to use the Surescripts network on my behalf to conduct a benefit investigation in connection with this enrollment form. I will comply with all of Surescripts' terms and conditions, including confidentiality, commercial messaging, privacy and security, applicable laws, and use of data, which I have reviewed. A full list of terms and conditions is available at https://ubc.com/surescriptsterms.
4. I authorize the above prescription and Program information to be forwarded by the argenx US, Inc. My VYVGART Path to the dispensing pharmacy in accordance with applicable law.

*Prescriber Signature: | *Date (MM/DD/YYYY):

7. Patient Authorization

Required for enrollment

PATIENT AUTHORIZATION TO COLLECT, USE AND DISCLOSE PROTECTED HEALTH INFORMATION

By signing below, I authorize my healthcare providers, pharmacies, and health plan(s) (collectively, my "Health Team") to disclose my personal information, including health information, on this form as well as other information relating to my medical condition, prescription, and insurance coverage (collectively, my "protected health information" or "PHI"), to argenx US, Inc., its affiliates, contractors, and agents, (collectively "argenx") in order for argenx to use and share with my Health Team the PHI as needed to: (1) enroll me in My VYVGART Path; (2) conduct benefits investigations and take related actions to determine my eligibility for, and coordinate financial assistance for me to receive, VYVGART; (3) communicate with my Health Team about my treatment plan; (4) provide me with support services including disease state and VYVGART education and resources; (5) help facilitate prescription fulfillment and product replacement; (6) facilitate quality control and related reporting activities; (7) de-identify my data and use the de-identified data for research and publication; (8) conduct data analytics, market research, and My VYVGART Path-related business activities; (9) contact me by postal mail, email, FAX, or telephone using my contact information on this form (or any future contact information provided by me or on my behalf) in connection with carrying out My VYVGART Path services, including adherence-related communications, reminders, and support, for which third-party service providers of my Health Team may receive financial remuneration from argenx; and (10) facilitate my participation in My VYVGART Path offerings about which I have elected to receive information.

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, but I also understand that argenx plans to use and disclose my PHI only as described in this authorization.
- 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 that 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.
- I am entitled to receive a copy of this authorization after I sign it.

*Patient Name (First, Last):	*Patient Signature	*Date (MM/DD/YYYY):

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

8. Marketing Consent

Optional

☐ I agree to receive emails promoting argenx products and services.

*Patient Name (First, Last):

*Patient Signature:

*Date (MM/DD/YYYY):

9. Mobile Messaging Consent

Optional

By signing below, I agree to be contacted by text messages ("texts") placed by argenx or its agents or service providers (collectively, "argenx") to the mobile phone number I have provided below, for the purpose of helping me stay on therapy, and which may promote or advertise argenx products and services. I certify that the number I am providing belongs to me and not a family member or third party. I understand that I may opt out of receiving such messages at any time by calling 1-833-MY-PATH-1 (1-833-697-2841) or replying "STOP" by text to any text from argenx and that my consent to being contacted by text messages is not a condition for me to participate in My VYVGART Path.

*Patient Name (First, Last):

*Mobile Phone Number:

*Patient Signature:

*Date (MM/DD/YYYY):

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

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