VYVGART® Hytrulo
(efgartigimod alfa and hyaluronidase-qvfc)
Subcutaneous Injection
180 mg/mL and 2000 U/mL vial

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

GENERALIZED MYASTHENIA GRAVIS (gMG)

My VYVGART Path Enrollment Form

To enroll in the Patient Support Program, fax the completed form to My VYVGART Path at **1-833-MY-V-PATH (1-833-698-7284)** or mail the form to My VYVGART Path, 680 Century Point, Suite 1000, Lake Mary, FL 32746. Office hours: Monday to Friday, 8 AM to 8 PM ET.

***Indicates required field.**

1. PATIENT INFORMATION

***Patient First Name:**

***Patient Last Name:**

***DOB (MM/DD/YYYY):**

***Patient Email:**

***Phone #:**

Alt Phone #:

***Patient Mailing Address:**

***City:**

***State:**

***Zip:**

Patient Gender: ☐ Male ☐ Female ☐ Non-Binary

Patient Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Is this your first prescription for VYVGART Hytrulo or VYVGART? ☐ Yes ☐ No

Please select which form of VYVGART you have been prescribed:

☐ VYVGART (efgartigimod alfa-fcab) for IV infusion

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

2. INSURANCE INFORMATION

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

Check here if you do not have insurance: ☐

	*Primary Benefit	Secondary Benefit	Pharmacy Benefit
***Insurance Name**			
***Policyholder Name:**			
***Policy ID #:**			
Relationship to Patient:			
Insurance Provider Phone #:			
Group #:			
PCN #:			
BIN #:			

3. PRESCRIBER INFORMATION

***Prescriber Name (First, Middle, Last):**

***Practice Name:**

***Office Phone #:**

***Practice Address:**

***City:**

***State:**

***Zip:**

4. 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 Hytrulo or VYVGART; communicate with my Health Team about my treatment plan; provide me with support services, including disease state and VYVGART Hytrulo or 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 833-697-2841 or mailing notice of revocation to My VYVGART Path, 680 Century Point, Suite 1000, Lake Mary, FL 32746; revocation will take effect 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 signing or on such earlier date as 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 PHI if our relationship involves receipt of compensation in exchange for data or in connection with providing PHI 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 PHI. I further authorize argenx to contact any individual(s) identified as an Authorized Caregiver, below, to discuss my medical condition or my participation in My VYVGART Path, and I understand that such discussions may require argenx to disclose my PHI to such Authorized Caregiver.

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

Authorized Caregiver Name and Phone #:

☐ *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.*

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