My VYVGART® Path **Patient self-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 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.

*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 this your first VYVGART prescription? ☐ 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 the patient has no insurance: ☐

*Primary Benefit Insurance Name:	*Policyholder Name:

Relationship to Patient:	Insurance Provider Phone #:	*Policy ID #:
Group #:	PCN #:	BIN #:
Pharmacy Benefit Insurance Name:	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:	*Practice Address:

*City:	*State:	*ZIP:	*Office Phone #:

4. PATIENT AUTHORIZATION TO COLLECT, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION

By signing below, I certify that, to the best of my knowledge, I have anti-AChR antibody positive gMG and have been prescribed VYVGART, and the information provided in this form is complete and accurate to the best of my knowledge. 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.*

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

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