

# Enrollment Form for HCPs



To enroll patients, **fax** the completed form to My VYVGART Path at **1-833-MY-V-PATH (1-833-698-7284)**. Office hours: Monday through Friday, 8 AM to 8 PM ET.



For questions, please contact My VYVGART Path at **1-833-MY-PATH-1 (1-833-697-2841)**.



Visit **MyPathEnroll.com** for more information.

## \*IMPORTANT

My patient has **GENERALIZED MYASTHENIA GRAVIS (gMG)**—please complete pages 1, 2, 4 (if applicable), and 5.

My patient has **CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP)**—please complete pages 1, 3, 4 (if applicable), and 5.

## 1. PATIENT INFORMATION \*Indicates required field.

<b>*Patient First Name:</b>		Patient Middle Initial:	<b>*Patient Last Name:</b>		
<input type="text"/>		<input type="text"/>	<input type="text"/>		
<b>*DOB (MM/DD/YYYY):</b>	<b>*Patient Email:</b>		<b>*Phone #:</b>	Alternate Phone #:	
<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	
<b>*Patient Mailing Address:</b>			<b>*City:</b>	<b>*State:</b>	<b>*Zip:</b>
<input type="text"/>			<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary		Patient-Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
Is your patient new to VYVGART Hytrulo or VYVGART? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Authorized Caregiver or Alternate Contact:</b> <i>By providing this information, you authorize My VYVGART Path to discuss the patient's health condition and participation in My VYVGART Path with the person named below.</i>					
Caregiver First Name:		Caregiver Middle Initial:	Caregiver Last Name:		
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Relationship to Patient:		Caregiver Email:	Caregiver Phone #:		
<input type="text"/>		<input type="text"/>	<input type="text"/>		

## 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:  Co-pay Program:  Yes  No Patient Assistance Program:  Yes  No

	*Primary Benefit	Secondary Benefit	Pharmacy Benefit
<b>*Insurance Name:</b>	<input type="text"/>		
<b>*Policyholder Name:</b>	<input type="text"/>		
<b>*Policy ID #:</b>	<input type="text"/>		
Relationship to Patient:	<input type="text"/>		
Insurance Provider Phone #:	<input type="text"/>		
Group #:	<input type="text"/>		
PCN #:	<input type="text"/>		
BIN #:	<input type="text"/>		

## 3. PRESCRIBER INFORMATION

<b>*Prescriber Name (First, Middle, Last):</b>			<b>*Practice Name:</b>		
<input type="text"/>			<input type="text"/>		
<b>*NPI #:</b>	<b>*Tax ID:</b>	<b>*State License #:</b>	Medicare/Medicaid Provider #:		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
<b>*Practice Address:</b>		<b>*City:</b>	<b>*State:</b>	<b>*Zip:</b>	
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>*Office Phone #:</b>	<b>*Office Fax #:</b>	Prescriber Email:			
<input type="text"/>	<input type="text"/>	<input type="text"/>			
Please provide direct contact information for an office contact who can handle access issues.					
Office Contact Name:		Office Contact Phone #:		Office Contact Email:	
<input type="text"/>		<input type="text"/>		<input type="text"/>	

# 4. \*gMG PRESCRIPTION INFORMATION

<b>*Patient First Name:</b> <input style="width:95%;" type="text"/>	<b>Patient Middle Initial:</b> <input style="width:95%;" type="text"/>	<b>*Patient Last Name:</b> <input style="width:95%;" type="text"/>	<b>*DOB (MM/DD/YYYY):</b> <input style="width:95%;" type="text"/>
<b>*Primary Diagnosis ICD-10 Code:</b> <input type="checkbox"/> G70.00 (Myasthenia gravis without acute exacerbation) <input type="checkbox"/> G70.01 (Myasthenia gravis with acute exacerbation)			
<b>gMG Type:</b> <input type="checkbox"/> Anti-AChR Antibody Positive (AChR=acetylcholine receptor) <input type="checkbox"/> Anti-MuSK Antibody Positive (MuSK=muscle-specific tyrosine kinase) <input type="checkbox"/> Triple Seronegative <input type="checkbox"/> Anti-LRP4 Antibody Positive (LRP4=low-density lipoprotein receptor-related protein 4)			
<b>Current Therapies:</b> <input type="checkbox"/> Treatment-naïve <input type="checkbox"/> Mestinon <input type="checkbox"/> Nonsteroidal ISTs <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Zilucoplan <input type="checkbox"/> Nipocalimab <input type="checkbox"/> Inebilizumab <input type="checkbox"/> Rituximab <input type="checkbox"/> Eculizumab <input type="checkbox"/> Rozanolixizumab <input type="checkbox"/> Ravulizumab-cwvz <input type="checkbox"/> IVIg/SCIg <input type="checkbox"/> Other _____			
<b>Previous Therapies:</b> <input type="checkbox"/> Treatment-naïve <input type="checkbox"/> Mestinon <input type="checkbox"/> Nonsteroidal ISTs <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Zilucoplan <input type="checkbox"/> Nipocalimab <input type="checkbox"/> Inebilizumab <input type="checkbox"/> Rituximab <input type="checkbox"/> Eculizumab <input type="checkbox"/> Rozanolixizumab <input type="checkbox"/> Ravulizumab-cwvz <input type="checkbox"/> IVIg/SCIg <input type="checkbox"/> Other _____ <input type="checkbox"/> VYVGART <input type="checkbox"/> VYVGART Hytrulo			
<b>Patient Allergies:</b> <input style="width:95%;" type="text"/>		<b>Current MG-ADL Score:</b> _____ <small>MG-ADL=Myasthenia Gravis Activities of Daily Living</small>	
		<b>MGFA Classification:</b> _____ <small>MGFA=Myasthenia Gravis Foundation of America</small>	

**Please select treatment. Complete the applicable prescription information section(s) based on this selection.**

<input type="checkbox"/> <b>VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection</b> <b>Prefilled syringe</b> <small>VYVGART Hytrulo is a fixed dose per injection.</small>	<b>gMG DOSING:</b> <b>1,000 mg efgartigimod alfa and 10,000 units hyaluronidase per 5.0 mL (200 mg/2,000 units per mL) in a single-dose prefilled syringe</b>	<b>DIRECTIONS:</b> Administer subcutaneously over approximately 20 to 30 seconds once weekly for 4 weeks (4 once-weekly injections = 1 treatment cycle) with _____ days between treatment cycles  ↻ Additional instruction: _____	<b>DISPENSE QUANTITY:</b> <input type="checkbox"/> 1 pack = 4 prefilled syringes for a 28-day supply	<b>REFILLS:</b> <b>*Number of refills authorized:</b> <input style="width:40px;" type="text"/>  <small>(4 once-weekly injections = 1 treatment cycle)</small>	<b>PREFERRED SITE OF CARE:</b> <input type="checkbox"/> Home injection <input type="checkbox"/> Prescriber's office  <input type="checkbox"/> Specialty pharmacy  ↻ Other instruction: _____
<input type="checkbox"/> <b>VYVGART (efgartigimod alfa-fcab) for intravenous use</b> <small>VYVGART dosing is weight-based. For assistance, visit <a href="http://VYVGARTHCP.com/gMGDosing">VYVGARTHCP.com/gMGDosing</a>.</small>	<b>gMG DOSING:</b> <b>10 mg/kg x patient weight (kg) = dose (mg)</b> <b>Strength: 400 mg/20 mL (20 mg/mL) in a 20-mL single-dose vial</b>  <b>CALCULATED DOSE:</b> <b>*Patient weight: <input style="width:40px;" type="text"/> kg</b> <small>To convert from lb to kg, divide the patient's weight in lb by 2.205. For patients weighing 120 kg or more, the dose should not exceed 1,200 mg (3 vials) per infusion.</small>  <input type="checkbox"/> _____ mg <input type="checkbox"/> <b>1,200 mg for patients greater than 120 kg based on weight</b>	<b>DIRECTIONS:</b> Infuse once weekly for 4 weeks (4 once-weekly infusions = 1 treatment cycle) with _____ days between infusion cycles  ↻ Additional instruction: _____	<b>REFILLS:</b> <b>*Number of refills authorized:</b> <input style="width:40px;" type="text"/>  <small>(4 once-weekly infusions = 1 treatment cycle)</small>	<b>PREFERRED SITE OF CARE:</b> <input type="checkbox"/> Prescriber's office <b>Buy and Bill:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Home infusion <input type="checkbox"/> Infusion center <input type="checkbox"/> Hospital outpatient <input type="checkbox"/> Patient's choice <input type="checkbox"/> Alternative site <input type="checkbox"/> Specialty pharmacy  ↻ Other instruction: _____	
<input type="checkbox"/> <b>VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection</b> <b>Vial</b> <small>VYVGART Hytrulo is a fixed dose per injection.</small>	<b>gMG DOSING:</b> <b>1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL (180 mg/2,000 units per mL) in a single-dose vial</b>	<b>DIRECTIONS:</b> Administer subcutaneously over approximately 30 to 90 seconds once weekly for 4 weeks (4 once-weekly injections = 1 treatment cycle) with _____ days between treatment cycles  ↻ Additional instruction: _____	<b>DISPENSE QUANTITY:</b> <input type="checkbox"/> 4 vials	<b>REFILLS:</b> <b>*Number of refills authorized:</b> <input style="width:40px;" type="text"/>  <small>(4 once-weekly injections = 1 treatment cycle)</small>	<b>PREFERRED SITE OF CARE:</b> <input type="checkbox"/> Prescriber's office <b>Buy and Bill:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Home injection <input type="checkbox"/> Infusion center <input type="checkbox"/> Hospital outpatient <input type="checkbox"/> Patient's choice <input type="checkbox"/> Alternative site <input type="checkbox"/> Specialty pharmacy  ↻ Other instruction: _____

### PRESCRIBER AUTHORIZATION AND ATTESTATION

By signing below, I certify that I am prescribing VYVGART Hytrulo or VYVGART for the patient identified herein, and that I have received permission from the patient and met other applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and applicable state laws needed to release the information that I am providing in this enrollment form. I understand that such information may be used by My VYVGART Path, its designated agents, service providers, and dispensing pharmacies for the purposes of verifying the patient's insurance coverage for VYVGART Hytrulo or VYVGART, confirming prior authorization requirements for VYVGART Hytrulo or 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 Hytrulo or VYVGART, and providing my patient with other education and support. I authorize My VYVGART Path, its affiliates, agents, and contractors to act on my behalf for the limited purposes of transmitting this prescription, by any means allowed under applicable law, to the appropriate pharmacy designated by the patient utilizing their benefit plan.

For the VYVGART Hytrulo prefilled syringe, the specialty pharmacy nurse will provide the patient with 2 self-injection trainings, including an assessment, subcutaneous administration, and education regarding medication preparation, VYVGART Hytrulo administration, and dosing. Additional trainings can be coordinated upon request. Needles, syringes, and ancillary supplies necessary for home administration will be provided.

ATTN: New York and Iowa providers, please submit an electronic prescription.

**Dispense As Written/Brand Medically Necessary/Do Not Substitute/No Substitution/DAW/May Not Substitute**

**\*Prescriber Signature:** \_\_\_\_\_ **\*Date (MM/DD/YYYY):**

\*Patient First Name:  Patient Middle Initial:  \*Patient Last Name:  \*DOB (MM/DD/YYYY):

\*Primary Diagnosis ICD-10 Code:  G61.81 (Chronic inflammatory demyelinating polyneuritis)

Patient Allergies:   No known allergies

Current Therapies:  Treatment-naïve  IVIg/SCIg  Corticosteroids  Other

Previous Therapies:  Treatment-naïve  IVIg/SCIg  Corticosteroids  Other   
 VYVGART Hytrulo

<input type="checkbox"/> <b>VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection</b> <b>Prefilled syringe</b> VYVGART Hytrulo is a fixed dose per injection.	<p><b>CIDP DOSING:</b></p> <p>1,000 mg efgartigimod alfa and 10,000 units hyaluronidase per 5.0 mL (200 mg/2,000 units per mL) in a single-dose prefilled syringe</p>	<p><b>DIRECTIONS:</b></p> <p>Administer subcutaneously over approximately 20 to 30 seconds once weekly</p> <p>➔ Additional instruction:  <input type="text"/></p>	<p><b>DISPENSE QUANTITY:</b></p> <p><input type="checkbox"/> 1 pack = 4 prefilled syringes for a 28-day supply</p>	<p><b>REFILLS:</b></p> <p>*Number of refills authorized:  <input type="text"/></p>	<p><b>PREFERRED SITE OF CARE:</b></p> <p><input type="checkbox"/> Home injection  <input type="checkbox"/> Prescriber's office</p> <p><input type="checkbox"/> Specialty pharmacy</p> <p>➔ Other instruction:  <input type="text"/></p>
<input type="checkbox"/> <b>VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection</b> <b>Vial</b> VYVGART Hytrulo is a fixed dose per injection.	<p><b>CIDP DOSING:</b></p> <p>1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL (180 mg/2,000 units per mL) in a single-dose vial</p>	<p><b>DIRECTIONS:</b></p> <p>Administer subcutaneously over approximately 30 to 90 seconds once weekly</p> <p>➔ Additional instruction:  <input type="text"/></p>	<p><b>DISPENSE QUANTITY:</b></p> <p><input type="checkbox"/> 4 vials</p>	<p><b>REFILLS:</b></p> <p>*Number of refills authorized:  <input type="text"/></p>	<p><b>PREFERRED SITE OF CARE:</b></p> <p><input type="checkbox"/> Prescriber's office  <b>Buy and Bill:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Home injection  <input type="checkbox"/> Infusion center  <input type="checkbox"/> Hospital outpatient  <input type="checkbox"/> Patient's choice  <input type="checkbox"/> Alternative site</p> <p><input type="checkbox"/> Specialty pharmacy</p> <p>➔ Other instruction:  <input type="text"/></p>

**PRESCRIBER AUTHORIZATION AND ATTESTATION**

By signing below, I certify that I am prescribing VYVGART Hytrulo for the patient identified herein, and that I have received permission from the patient and met other applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and applicable state laws needed to release the information that I am providing in this enrollment form. I understand that such information may be used by My VYVGART Path, its designated agents, service providers, and dispensing pharmacies for the purposes of verifying the patient's insurance coverage for VYVGART Hytrulo, confirming prior authorization requirements for VYVGART Hytrulo, 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 Hytrulo, and providing my patient with other education and support. I authorize My VYVGART Path, its affiliates, agents, and contractors to act on my behalf for the limited purposes of transmitting this prescription, by any means allowed under applicable law, to the appropriate pharmacy designated by the patient utilizing their benefit plan.

For the VYVGART Hytrulo prefilled syringe, the specialty pharmacy nurse will provide the patient with 2 self-injection trainings, including an assessment, subcutaneous administration, and education regarding medication preparation, VYVGART Hytrulo administration, and dosing. Additional trainings can be coordinated upon request. Needles, syringes, and ancillary supplies necessary for home administration will be provided.

ATTN: New York and Iowa providers, please submit an electronic prescription.

Dispense As Written/Brand Medically Necessary/Do Not Substitute/No Substitution/DAW/May Not Substitute

\*Prescriber Signature:

\*Date (MM/DD/YYYY):

### 5. VYVGART HYTRULO QUICK START PROGRAM

» **OPTIONAL:** Complete this page if you are requesting a Quick Start shipment for your patient. The VYVGART Hytrulo Quick Start Program provides a limited supply of medication at no charge to **eligible patients with commercial insurance only**. Eligible patients must be starting VYVGART Hytrulo for the first time and should not have previously received VYVGART for IV infusion.

<b>*Patient First Name:</b> <input style="width:95%;" type="text"/>	<b>Patient Middle Initial:</b> <input style="width:95%;" type="text"/>	<b>*Patient Last Name:</b> <input style="width:95%;" type="text"/>	<b>*DOB (MM/DD/YYYY):</b> <input style="width:95%;" type="text"/>
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**\*Place of Administration/Ship to:**

Prescriber's office

Patient's home

#### gMG PRESCRIPTION INFORMATION

<input type="checkbox"/> <b>VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection</b>  <b>Prefilled syringe</b>  VYVGART Hytrulo is a fixed dose per injection.	<b>gMG DOSING:</b> 1,000 mg efgartigimod alfa and 10,000 units hyaluronidase per 5.0 mL (200 mg/2,000 units per mL) in a single-dose prefilled syringe  <b>Number of refills (treatment cycles) authorized: <u>  2  </u> refills</b> (4 once-weekly injections = 1 treatment cycle)	<b>DIRECTIONS:</b>  Administer subcutaneously over approximately 20 to 30 seconds once weekly for 4 weeks (4 once-weekly injections = 1 treatment cycle) with <u>  4  </u> weeks between treatment cycles	<b>ADDITIONAL INSTRUCTIONS</b>  <div style="border: 1px solid #ccc; height: 60px;"></div>
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<input type="checkbox"/> <b>VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection</b>  <b>Vial</b>  VYVGART Hytrulo is a fixed dose per injection.	<b>gMG DOSING:</b> 1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL (180 mg/2,000 units per mL) in a single-dose vial  <b>Number of refills (treatment cycles) authorized: <u>  2  </u> refills</b> (4 once-weekly injections = 1 treatment cycle)	<b>DIRECTIONS:</b>  Administer subcutaneously over approximately 30 to 90 seconds once weekly for 4 weeks (4 once-weekly injections = 1 treatment cycle) with <u>  4  </u> weeks between treatment cycles	<b>ADDITIONAL INSTRUCTIONS</b>  <div style="border: 1px solid #ccc; height: 60px;"></div>
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#### CIDP PRESCRIPTION INFORMATION

<input type="checkbox"/> <b>VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection</b>  <b>Prefilled syringe</b>  VYVGART Hytrulo is a fixed dose per injection.	<b>CIDP DOSING:</b> 1,000 mg efgartigimod alfa and 10,000 units hyaluronidase per 5.0 mL (200 mg/2,000 units per mL) in a single-dose prefilled syringe  <b>Dispense quantity: <u>  4  </u></b> (Dispensed as single-dose syringes)  <b>Refills: <u>  5  </u> refills</b>	<b>DIRECTIONS:</b>  Administer subcutaneously over approximately 20 to 30 seconds once weekly	<b>ADDITIONAL INSTRUCTIONS</b>  <div style="border: 1px solid #ccc; height: 60px;"></div>
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<input type="checkbox"/> <b>VYVGART Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for subcutaneous injection</b>  <b>Vial</b>  VYVGART Hytrulo is a fixed dose per injection.	<b>CIDP DOSING:</b> 1,008 mg efgartigimod alfa and 11,200 units hyaluronidase per 5.6 mL (180 mg/2,000 units per mL) in a single-dose vial  <b>Dispense quantity: <u>  4  </u></b> (Dispensed as single-dose vials)  <b>Refills: <u>  5  </u> refills</b>	<b>DIRECTIONS:</b>  Administer subcutaneously over approximately 30 to 90 seconds once weekly	<b>ADDITIONAL INSTRUCTIONS</b>  <div style="border: 1px solid #ccc; height: 60px;"></div>
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#### → \*PRESCRIBER INFORMATION

<b>*Prescriber Name (First, Middle, Last):</b> <input style="width:95%;" type="text"/>	<b>*NPI #:</b> <input style="width:95%;" type="text"/>	<b>*State License #:</b> <input style="width:95%;" type="text"/>
<b>*Practice Address:</b> <input style="width:95%;" type="text"/>	<b>*City:</b> <input style="width:95%;" type="text"/>	<b>*State:</b> <input style="width:95%;" type="text"/>
<b>*Office Phone #:</b> <input style="width:95%;" type="text"/>	<b>*Office Fax #:</b> <input style="width:95%;" type="text"/>	

#### PRESCRIBER AUTHORIZATION AND ATTESTATION

The VYVGART Hytrulo Quick Start Program supplies medication to eligible commercial patients with a confirmed coverage delay of 5 calendar days. Eligible patients must have commercial insurance and be starting VYVGART Hytrulo for the first time. The program can provide up to 3 shipments for gMG and 6 shipments for CIDP.

I understand that the medication provided is complimentary and that no claim may be made to any patient or third-party payer (e.g., Medicare, Medicaid, and or commercial insurance) for payment for VYVGART Hytrulo provided under the Quick Start Program and that such product cannot be sold, traded, or returned for credit. argenx reserves the right to rescind, revoke, or amend this program without notice at any time.

When home location is selected, a healthcare provider is to administer VYVGART Hytrulo subcutaneously or train on self-administration when the VYVGART Hytrulo prefilled syringe is selected. My signature on the form indicates that this injection requires home infusion services by a specialty pharmacy-associated provider.

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

**➔ 6. PATIENT AUTHORIZATION TO COLLECT, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION (Required for enrollment into the My VYVGART Path Patient Support Program)**

By signing below, I authorize my healthcare providers, pharmacies, and health plans (collectively, my “Health Team”) to: disclose and re-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.

<b>*Patient Name:</b>		<b>*DOB (MM/DD/YYYY):</b>	
<b>*Patient Signature:</b>			
<b>Caregiver Name and Signature:</b>			

- Check here to receive patient education program information, engagement communication requests from argenx, and emails promoting argenx products and services.*
- By checking, you are agreeing to receive promotional and/or marketing SMS communications from argenx. Consent is not a condition of any service or purchase. Frequency may vary. Message and data rates may apply. Reply HELP for help or STOP to opt out.*



For questions, please contact My VYVGART Path at:  
**1-833-MY-PATH-1** (1-833-697-2841)