NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Insured Coverage of Efgartigimod Alfa (Vyvgart)

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

INITIAL REQUEST

☐ Diagnosis of generalized myasthenia gravis (gMG)

☐ Positive serologic test for anti-AChR antibodies

☐ An MG-ADL score at baseline of ≥ 5. Baseline MG-ADL score: _____ Date: _____

☐ MGFA class II to IV disease. MGFA class: _____

☐ Prescribed by or in consultation with a neurologist with expertise in managing patients with gMG.

☐ Symptoms persist despite an adequate trial and stable dose of conventional therapy with acetylcholinesterase inhibitors (pyridostigmine) **AND** corticosteroids (prednisone) **AND/OR** nonsteroidal immunosuppressants (azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, or tacrolimus) **(Please provide details below)**

☐ Not used concomitantly with rituximab or complement inhibitors

EXCLUSION CRITERIA

☐ Yes ☐ No Is the patient currently experiencing a gMG exacerbation or crisis?

☐ Yes ☐ No Is the patient within 3 months of thymectomy?

MEDICATION TRIALS

Medication (Please specify)	Dose	Duration	Outcome
☐ Acetylcholinesterase Inhibitor: _____			
☐ Corticosteroid: _____			
☐ Nonsteroidal Immunosuppressant: _____			

RENEWAL REQUEST

INITIAL RENEWAL

☐ After the initial 3 cycles of treatment, there is documented improvement in MG-ADL score of 2 points or greater.

MG-ADL score:_____ Date: _____

SUBSEQUENT RENEWAL

☐ No worsening of MG-ADL score since last renewal.

PRESCRIBER NAME & ADDRESS:

_____ **LICENCE #**

_____ **PRESCRIBER SIGNATURE**

_____ **DATE**

If you need assistance, please contact the Pharmacare Office at (902) 496-7001 or 1-800-305-5026

Please Return Form To: Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2S1; Fax: (902) 496-4440

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NOVA SCOTIA