REALRx

PRIOR AUTHORIZATION REQUEST FORM
RUZURGI®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Ruzurgi® (amifampridine)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
2. Is the requesting prescriber a neurologist?	☐	☐	
3. Has the following diagnosis been ruled out: • Myasthenia gravis • Parkinsonism • Peripheral neuropathy • Myopathy • Lumbar spinal stenosis • Psychologic issues • Amyotrophic lateral sclerosis • Guillain-Barre syndrome	☐	☐	**Please provide documentation**
4. Has the diagnosis of Lambert-Eaton Myasthenic Syndrome been confirmed with the following tests: • Presence of antibodies to P/Q type voltage-gates calcium channels in serum • Single fiber electromyography	☐	☐	**Please provide documentation**
5. Is the member experiencing moderate to severe weakness?	☐	☐	**Please provide documentation**

6. Has the member been screened for malignancy (particularly small cell lung cancer)?	☐	☐	**Please provide documentation**
7. If malignancy is present, does the member meet one of the following: • Underlying malignancy has been treat for at least 3 months • Member has severe LMS symptoms and underlying malignancy is currently being treated • The member's malignancy is unable to be treated	☐	☐	**Please provide documentation**
8. Has the member's medication list been reviewed for any therapies that could aggravate or induce myasthenia (antibiotics, cardiovascular medications, neurological and psychoactive medications, etc.)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Does documentation show a clinically meaningful response to therapy demonstrating improvement of disease and/or updated results of a single fiber electromyography?	☐	☐	**Please provide documentation**
4. Was the member's initial malignancy screening negative? • If yes, go to question 5.	☐	☐	**Please provide documentation of initial screening and recent screening**
5. Has a chest CT scan been done within the past 6 months OR has malignancy been ruled out after at least 2 years of CT scan surveillance?	☐	☐	**Please provide documentation of initial screening and recent screening**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy PHARM- 084
Origination Date: 09/04/2019
Reviewed/Revised Date: 10/13/2021
Next Review Date: 10/13/2022
Current Effective Date: 11/01/2021