HEALTHY U MEDICAID

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

MYASTHENIA GRAVIS

Rystiggo®, Soliris®, Ultomiris®, Vyvgart®, Vyvgart® Hytrulo, Zilbrysq®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U P Plans Prior Authorization Department at 801-213-1547.

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 Pharmacy Customer Service for assistance at 833-981-0212

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:		HCPCS Code:

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.

Preferred/Non-preferred

1. 1st line preferred agents:
   A. Rystiggo® (rozanolixizumab-noli) subcutaneous infusion, Vyvgart® (efgartigimod alfa-fcab) intravenous infusion
2. 2nd line non-preferred agents; after trial and failure of the preferred first-line agents:
   A. Ultomiris® (ravulizumab) intravenous infusion
3. Excluded/Not covered unless failure or contraindication to all other agents:
   A. Soliris® (eculizumab) intravenous infusion; Vyvgart® Hytrulo (efgartigimod alfa/hyaluronidase) subcutaneous infusion, Zilbrysq® (zilucoplan)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
MYASTHENIA GRAVIS (gMG)			
1. Is the request being made by or in consultation with a neurologist or other specialist in the treatment of gMG?	☐	☐	
2. Does the member have a diagnosis of gMG?	☐	☐	
3. Does the member have a positive serologic test for anti-acetylcholine receptor (anti-AchR) antibodies?	☐	☐	**Please provide documentation**
4. If the request is for Rystiggo®, does the member have a positive serologic test for anti-acetylcholine receptor (anti-AchR) antibodies OR anti-muscle-specific kinase (anti-MuSK) antibodies?	☐	☐	**Please provide documentation**
5. Has the member been diagnosed with class II to IV gMG according to the Myasthenia Gravis Foundation of America?	☐	☐	**Please provide documentation**

6. Has the member tried and failed pyridostigmine AND at least two immunosuppressive therapies (e.g. rituximab, methotrexate, mycophenolate mofetil, azathioprine, cyclosporine) for a total duration of at least 12 months?	☐	☐	**Please provide documentation**
7. Has the member tried and failed intravenous immunoglobulin (IVIG)?	☐	☐	**Please provide documentation**
8. Will the requested therapy be used in combination with IVIG or other biologic agents for gMG treatment?	☐	☐	
9. If the request is for Rystiggo®, is the member's Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 3?	☐	☐	**Please provide documentation**
10. If the request is for Vyvgart®, is the member's MG-ADL score ≥ 5?	☐	☐	**Please provide documentation**
11. If the request is for Soliris® or Ultomiris®, is the member's MG-ADL score ≥ 6?	☐	☐	**Please provide documentation**
12. If the request is for Soliris® or Ultomiris®, is the prescribing physician enrolled in Soliris® or Ultomiris® REMS program?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. If the request is for reauthorization of Vyvgart® or Rystiggo®, has the member had a positive clinical response to treatment shown by a ≥ 2 points reduction in MG-ADL score?	☐	☐	**Please provide documentation**
3. If the request is for reauthorization of Soliris® or Ultomiris®, has the member had a positive clinical response to treatment shown by a ≥ 2 points reduction in MG-ADL score or a ≥ 3 points reduction in quantitative myasthenia gravis (QMG) score?	☐	☐	**Please provide documentation**
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's Signature:			

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Policy: PHARM-HU-M046
Origination Date: 08/03/2023
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