SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Generalized Myasthenia Gravis (gMG) (Medical)

Drug Requested: (Select one drug below)

❑ **Vyvgart®** (efgartigimod alfa-fcab) **IV (J9332)**	❑ **Vyvgart® Hytrulo** (efgartigimod alfa-fcab/hyaluronidase-qvfc) **SC (J9334)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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Recommended Dosage:

Drug	Dosing and Quantity Limit
Vyvgart (efgartigimod alfa-fcab) 400 mg/20 mL single-dose vial	• The recommended dosage is 10 mg/kg administered as an intravenous infusion over one hour once weekly for 4 weeks. In patients weighing 120 kg or more, the recommended dose is 1200 mg per infusion. • **Quantity limit: 3 vials per week for four doses; 200 billable units per vial = 600 billable units per week** • **Maximum Dose (over time) – 1200 mg weekly for four doses**
Vyvgart Hytrulo (efgartigiomod alfa/ hyaluronidase-qvfc) 1,008 mg/11,200 units per 5.6 mL single-dose vial	• The recommended dosage is 1,008 mg/11,200 units administered subcutaneously over approximately 30 to 90 seconds in cycles of once weekly injections for 4 weeks. • **Quantity limit: 1 vial per week for four doses = 504 billable units per vial per week** • **Maximum Dose (over time) – 1,008 mg/11,200 units weekly for four doses**
Vyvgart Hytrulo (efgartigiomod alfa/ hyaluronidase-qvfc) 1,000 mg/10,000 units per 5 mL single-dose prefilled syringe	• The recommended dosage is 1,000 mg/10,000 units administered subcutaneously over approximately 20 to 30 seconds in cycles of once weekly injections for 4 weeks. • **Quantity limit: 1 syringe per week for four doses** • **= 500 billable units per syringe per week** • **Maximum Dose (over time) – 1,000 mg/10,000 units weekly for four doses**

- Administer subsequent treatment cycles based on clinical evaluation

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ❑ Must be prescribed by, or in consultation with, a neurologist or other specialist in myasthenia gravis
- ❑ Member must be 18 years of age or older
- ❑ Member has a diagnosis of generalized Myasthenia Gravis (gMG) and **all** of the following:
  - ❑ Member has a Myasthenia Gravis Foundation of America (MGFA) clinical classification class of II-IVb
  - ❑ Member has a MG-Activities of Daily Living total score of greater than or equal to 5

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- ❑ **One** of the following:
  - ❑ Member has tried and had an inadequate response after an adequate trial to at least two immunosuppressive therapies (e.g., azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide) (either combination or monotherapy)
  - ❑ Member has an intolerance or hypersensitivity to at least **two** immunosuppressive therapies
  - ❑ Member has tried and had an inadequate response after an adequate trial to treatment to at least **one** immunosuppressive therapy (e.g., azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide) **and one** of the following:
    - ❑ Member required chronic intravenous immunoglobulin (IVIG)
    - ❑ Member required chronic plasmapheresis/plasma exchange
- ❑ Member will **not** be using the requested agent in combination with Rystiggo (rozanolixizumabnoli), Soliris (eculizumab), Bkemv (eculizumab-aeeb), Epysqli (eculizumab-aagh), Ultomiris (ravulizumab-cwvz), Zilbrysq (zilucoplan), or Imaavy (nipocalimab-aahu)
- ❑ If requesting **Vyvgar**t or **Vyvgart Hytrulo vial**:
  - ❑ Member has tried self-administered Vyvgart Hytrulo
  - ❑ There is support for use of a provider-administered product over the self-administered product

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet the relevant criteria identified in the initial criteria
- ❑ Member has an absence of unacceptable toxicity from the drug
- ❑ Member is being continuously monitored for a beneficial response to therapy

Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:**
  NPI or DEA # of administering location:

  OR
- ❑ Specialty Pharmacy

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee:** ~~3/17/2022; 9/21/2023; 7/24/2025; 11/20/2025; 1/22/2026;~~ **7/23/2026**
REVISED/UPDATED/REFORMATTED: ~~5/9/2022; 6/16/2022; 10/17/2023; 3/15/2024; 7/9/2025; 8/18/2025, 12/8/2025; 2/18/2026; 8/28/2026~~; **9/23/2026**