SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Vyvgart® Hytrulo (efgartigimod alfa/hyaluronidase-qvfc) **(PHARMACY)**
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

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:** _____

Recommended Dosing: SUBQ: 1,000 mg efgartigimod alfa/10,000 units hyaluronidase once weekly.

Quantity Limit: 4 syringes per 28 days

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.

Length of Authorization: Initial coverage will be provided for 6 months and may be renewed annually thereafter

- ❑ Member is 18 years of age or older
- ❑ Prescribed by or in consultation with a specialist for CIDP
- ❑ Member has progressive or relapsing and remitting CID for > 2 months **(submit documentation)**

(Continued on next page)

- ❑ Member was determined to have Probable or Definite CIDP according to EFNS/PNS 2010
- ❑ Member has decreased or absent deep tendon reflexes in upper or lower limbs
- ❑ Electrodiagnostic testing indicating demyelination must meet **TWO** of the following:
  - ❑ Partial motor conduction block in at least 2 motor nerves or in 1 nerve plus one other demyelination criterion listed here in at least 1 other nerve
  - ❑ Distal CMAP duration increase in at least 1 nerve plus one other demyelination criterion listed here in at least 1 other nerve
  - ❑ Abnormal temporal dispersion conduction must be present in at least 2 motor nerves
  - ❑ Reduced motor conduction velocity in at least 2 motor nerves
  - ❑ Prolonged distal motor latency in at least 2 motor nerves
  - ❑ Absent F wave in at least 2 motor nerves plus one other demyelination criterion listed here in at least 1 other nerve
  - ❑ Prolonged F wave latency in at least 2 motor nerves
  - ❑ ≥30% amplitude reduction of the proximal negative peak CMAP relative to distal, excluding the posterior tibial nerve, if distal negative peak CMAP≥20% of LLN, in two nerves, or in one nerve + ≥1 other demyelinating parameter in ≥1 other nerve
- ❑ Member has a baseline CIDP Disease Activity Status (CDAS) score ≥ 2 **(submit documentation)**
- ❑ Members baseline in strength/weakness has been documented using an objective clinical measuring tool (e.g., INCAT, Medical Research Council (MRC) muscle strength **(submit documentation)**
- ❑ Member has tried and failed at least a 3-month trial of immunoglobulin (IG) or plasma exchange therapy **(submit documentation to support inadequate efficacy)**
- ❑ Requested medication will **NOT** be used as maintenance therapy in combination with immunoglobulin or intravenous efgartigimod

Medication being provided by Specialty Pharmacy – Proprium Rx

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**: **5/22/2025**
REVISED/UPDATED/REFORMATTED: 6/9/2025