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-fcab/hyaluronidase-qvfc) **(Pharmacy)**
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

[Form to be completed **ONLY** **if the member is self-administering**]

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 neurologist or other specialist in CIDP

(Continued on next page)

- ❑ Member has a diagnosis of CIDP **and all** of the following:
  - ❑ Member's disease course is progressive or relapsing and remitting for at least 2 months
  - ❑ Member has progressive or relapsing motor sensory impairment of more than one limb
  - ❑ Member has electrodiagnostic findings indicating demyelination with at least ONE of the following:
    - ❑ Prolonged distal motor latency in at least 2 motor nerves
    - ❑ Reduced motor conduction velocity in at least 2 motor nerves
    - ❑ Prolonged F-wave 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
    - ❑ Partial motor conduction block in at least 2 motor nerves or in 1 nerve plus one other demyelination criterion listed here
    - ❑ Abnormal temporal dispersion conduction in at least 2 motor nerves
    - ❑ Distal CMAP duration increase in at least 1 nerve plus one other demyelination criterion listed here in at least 1 other nerve
- ❑ Member has tried and had an inadequate response to at least a 3-month trial of ONE standard of care therapy (i.e., corticosteroids, immunoglobulins, plasma exchange), unless contraindicated or intolerant

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 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: ~~6/4/2025; 8/15/2025,~~ **9/18/2026**