SENTARA HEALTH PLANS

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)
Generalized Myasthenia Gravis (gMG)

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 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 for 4 weeks. Subsequent treatment cycles of 1,000 mg efgartigimod alfa/10,000 units hyaluronidase once weekly for 4 weeks may be administered based on clinical evaluation and no sooner than 50 days from the start of the previous treatment cycle.

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.

Initial Authorization: 6 months

- ❑ Prescribing physician must be a neurologist
- ❑ Member must be 18 years of age or older

(Continued on next page)

- ❑ Member must have Myasthenia gravis Foundation of America (MGFA) Clinical Classification of Class II to IV disease and have a positive serologic test for anti-acetylcholine receptor (AchR) antibodies (lab test must be submitted)
- ❑ Physician has assessed objective signs of neurological weakness and fatigability on a baseline neurological examination (e.g., including but not limited to the Quantitative Myasthenia Gravis (QMG) score) **(chart notes must be submitted**)
- ❑ Member has a baseline MG-Activities of Daily Living (MG-ADL) total score ≥ 5 **(results must be submitted)**
- ❑ Member has a baseline immunoglobulin G (IgG) level of at least 6 g/L (600 mg) **(results must be submitted)**
- ❑ Member has **ONE** of the following **(verified by chart notes or pharmacy paid claims)**:
  - ❑ Member has tried and had an inadequate response to pyridostigmine
  - ❑ Member has an intolerance, hypersensitivity or contraindication to pyridostigmine
- ❑ Member has **ONE** of the following **(verified by chart notes or pharmacy paid claims)**:
  - ❑ Member failed over 1 year of therapy with at least 2 immunosuppressive therapies (e.g., azathioprine, cyclosporine, mycophenolate)
  - ❑ Member failed at least 1 immunosuppressive therapy and required chronic plasmapheresis, plasma exchange (PE) or intravenous immunoglobulin (IVIG)
- ❑ Member will avoid or use with caution medications known to worsen or exacerbate symptoms of MG (e.g., aminoglycosides, fluoroquinolones, beta-blockers, botulinum toxins, hydroxychloroquine)
- ❑ Member does **NOT** have an active infection, including clinically important localized infections
- ❑ Requested medication will **NOT** be administered with live-attenuated or live vaccines during treatment
- ❑ Medication will **NOT** be used in combination with other immunomodulatory biologic therapies (e.g., rituximab, eculizumab, ravulizumab, rozanolixizumab-noli, zilucoplan, nipocalimab-aahu)

Reauthorization: 6 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 all initial authorization criteria
- ❑ Member has **NOT** experienced unacceptable toxicity from the drug (e.g., infections, severe hypersensitivity reactions infusion reactions)
- ❑ Member meets **ONE** of the following:
  - ❑ Member has demonstrated an improvement of at least 2 points in the MG-ADL total score from baseline sustained for at least 4 weeks (**results must be submitted to document improvement**)
  - ❑ Member has demonstrated an improvement of at least 3 points from baseline in the Quantitative Myasthenia Gravis (QMG) total score sustained for at least 4 weeks **(results must be submitted to document improvement)**

(Continued on next page)

- ❑ Member requires continuous treatment, after initial beneficial response, due to new or worsening disease activity **(Note: a minimum of 50 days must have elapsed from the start of the previous treatment cycle)**

EXCLUSIONS – Therapy will NOT be approved if member has history of any of the following:

- MGFA Class I or MG crisis at initiation of treatment (MGFA Class V)
- Use of rituximab within 6 months prior to treatment
- Use of IVIG or PE within 4 weeks prior to treatment
- Any active or clinically significant infections that has not been treated

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;~~ **7/24/2025**
REVISED/UPDATED/REFORMATTED: ~~6/11/2025;~~ **8/22/2025**