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)
Generalized Myasthenia Gravis (gMG)

[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 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.

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

- ❑ Member will be self-administering Vyvgart Hytrulo
- ❑ Must be prescribed by, or in consultation with, a neurologist or other specialist in myasthenia gravis

(Continued on next page)

- ❑ Member must be 18 years of age or older
- ❑ Member has a diagnosis of 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
- ❑ **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)

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 form 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; 7/24/2025; 11/20/2025~~**;7/23/2026**
REVISED/UPDATED/REFORMATTED: ~~6/11/2025; 8/18/2025; 12/8/2025; 2/18/2026; 8/28/2026~~**; 9/24/2026**