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**.

IV Eculizumab Products - Generalized Myasthenia Gravis (gMG)

Drug Requested: select one drug below **(MEDICAL)**

❑ **Bkemv®** (eculizumab-aeeb) **Q5152**	❑ **Epysqli®** (eculizumab-aagh) **Q5151**	❑ **Soliris®** (eculizumab) **J1299**

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:

Patient Body Weight	Induction	Maintenance
40 kg and over	900 mg weekly for the first 4 weeks	1200 mg at week 5; then 1200 mg every 2 weeks
30 kg to less than 40 kg	600 mg for the first 2 weeks	900 mg at week 3; then 900 mg every 2 weeks
20 kg to less than 30 kg	600 mg for the first 2 weeks	600 mg at week 3; then 600 mg every 2 weeks
10 kg to less than 20 kg	600 mg single dose at week 1	300 mg at week 2; then 300 mg every 2 weeks
5 kg to less than 10 kg	300 mg single dose at week 1	300 mg at week 3; then 300 mg every 3 weeks

Maximum Quantity Limit: 4 vials every 14 days; one 300 mg vial (30 mL) = 150 billable units [1 billable unit per 2 mg]

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 must be 6 years of age or older
- ❑ Member has a positive serological test for anti-AChR antibodies **(documentation required)**
- ❑ Member must have Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IVb
- ❑ Member has a MG-Activities of Daily Living (MG-ADL) total score of ≥ 6 **(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 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),
- ❑ Vyvgart (efgartigimod), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc), Zilbrysq (zilucoplan), or Imaavy (nipocalimab-aahu)
- ❑ Member will **not** be using the requested agent in combination with Ultomiris (ravulizumab-cwvz), Bkemv (eculizumab-aeeb), or Epysqli (eculizumab-aagh)
- ❑ Member is free of Neisseria meningitidis infection

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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 all 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

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

- Unresolved meningococcal disease

Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health'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**: ~~2/15/2018; 8/15/2019; 7/21/2022; 9/21/2023; 3/27/2025; 5/22/2025; 7/24/2025; 11/20/2025;~~ **1/22/2026**
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