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**.

Drug Requested: Ultomiris® (ravulizumab-cwvz) **IV (J1303) (Medical)**
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 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.

Recommended Dosage:

- Weight-based dosage regimen administered intravenously as a loading dose. Two weeks later begin maintenance doses once every 8 weeks (depending on body weight). **Maximum Quantity Limit – 13 vials every 56 days.**

Body Weight Range (kg)	Loading Dose (mg)	Maintenance Dose (mg)
≥40 kg to <60 kg	2,400	3,000
≥60 kg to <100 kg	2,700	3,300
≥100 kg	3,000	3,600

(Continued on next page)

- Members switching from Soliris® to Ultomiris® administer the loading dose of Ultomiris® 2 weeks after the last Soliris® infusion, and then administer maintenance doses once every 8 weeks, starting 2 weeks after loading dose administration as above.

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 18 years of age or older
- ❑ Must be prescribed by, or in consultation with, a neurologist or other specialist in myasthenia gravis
- ❑ Member must have a diagnosis of generalized Myasthenia Gravis and **all** of the following: (**chart notes must be submitted**)
  - ❑ Member has a positive serological test for anti-AChR antibodies (medical records required)
  - ❑ 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 6
- ❑ Member has **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 is free of *Neisseria meningitidis* infection
- ❑ Medication will **NOT** be used in combination with other immunomodulatory biologic therapies (e.g.,eculizumab, zilucoplan, rituximab, efgartigimod alfa-fcab, efgartigimod alfa and hyaluronidase-qvfc, rozanolixizumab-noli, nipocalimab-aahu, inebilizumab-cdon)

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 authorization criteria

(Continued on next page)

- ❑ Member has **NOT** experienced unacceptable toxicity from the drug (e.g., serious meningococcal infections (septicemia and/or meningitis), infusion reactions, serious infections)
- ❑ 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**

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan'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:** ~~7/21/2022; 9/21/2023;~~ **11/20/2025**
REVISED/UPDATED/REFORMATTED: ~~8/7/2022; 10/17/2023; 3/15/2024; 8/18/2025, 12/08/2025; 2/18/2026,~~ **8/11/2026**