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: Vyvgart® Hytrulo (efgartigimod alfa/hyaluronidase-qvfc) **(J9334) (Medical)**
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

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.

- **Quantity Limit** (max daily dose) [NDC Unit]:
  - Vyvgart Hytrulo 1,008 mg/11,200 units (efgartigimod alfa/hyaluronidase) single-dose vial: 1 vial per week
  - Vyvgart Hytrulo 1,000 mg/10,000 units (efgartigimod alfa/hyaluronidase) single-dose prefilled syringe: 1 syringe per week
- **Max Units** (per dose and over time) [HCPCS Unit]:
  - 1,008 mg/11,200 units: 504 billable units per vial per week
  - 1,000 mg/10,000 units: 500 billable units per syringe per week

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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
- ❑ 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;
- ❑ One of the following:
  - ❑ Member has tried self-administered Vyvgart Hytrulo
  - ❑ There is support for use of a provider-administered product over the self-administered product

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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 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 (check applicable box(es) below):

❑ **Physician's office** **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**: 9/26/2024
REVISED/UPDATED/REFORMATTED: ~~10/15/2024; 7/9/2025; 8/15/2025;~~ **9/24/2026**