Vyvgart
(efgartigimod alfa-fcab)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:

☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:

☐ Vyvgart 400 mg/20 mL (20 mg/mL) vial
☐ other (please specify):

ICD10:

Directions for use: Dose Quantity: Duration of therapy:

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start".

☐ New start
☐ Continuation of therapy

(if continuation of therapy) Has your patient had a beneficial response to this medication? Note: Examples of beneficial response include reductions in exacerbations of myasthenia gravis; improvements in speech, swallowing, mobility, respiratory function, improvement in MG-ADL or QMG scores. ☐ Yes ☐ No

(if no) Please provide support for continued use in your patient.

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):

☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:

Address (City, State, Zip Code):

What is your patient's diagnosis?

☐ generalized Myasthenia Gravis
☐ other (please specify):

Clinical Information:
****This drug requires supportive documentation (chart notes, genetic test results, lab test results, etc) be attached with this request****

Is the patient's generalized myasthenia gravis confirmed to be anti-acetylcholine receptor antibody positive? ☐ Yes ☐ No

Prior to starting therapy with Vyvgart or Vyvgart Hytrulo, what is/was the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification class?
☐ Class I (pure ocular)
☐ Class II (mild generalized)
☐ Class III (moderate generalized)
☐ Class IV (severe generalized)
☐ Class V (intubation/myasthenic crisis)

Prior to starting therapy with Vyvgart or Vyvgart Hytrulo, does/did the patient have MG-Activities of Daily Living (MG-ADL) score of 5 or higher? ☐ Yes ☐ No

Is this medication being prescribed by, or in consultation with, a neurologist? ☐ Yes ☐ No

The covered alternative is pyridostigmine. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried pyridostigmine, but it didn't work.
☐ The patient is currently receiving pyridostigmine.
☐ The patient tried pyridostigmine, but they did not tolerate it.
☐ The patient cannot try pyridostigmine because of a contraindication to this drug.
☐ Other

Prior to starting therapy with Vyvgart or Vyvgart Hytrulo, does/did your patient have objective evidence of unresolved symptoms of generalized myasthenia gravis (gMG), such as difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity (for example, double vision, impairment of speech or mobility)? ☐ Yes ☐ No

Will your patient be treated with rituximab, (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima), Ultomiris, Soliris or immune globulin (IVIG) while receiving this medication? ☐ Yes ☐ No

(if yes) Please explain and provide clinical rationale for concurrent use of these drugs.

How much does the patient weigh?
☐ less than 120 kg
☐ 120 kg or more

Please provide the start date of the previous treatment cycle as well as the anticipated start date of this next cycle. If new to therapy, please answer "not applicable".

Will there be a minimum of 50 days between all treatment cycles (measured from the start date of the previous cycle)? ☐ Yes ☐ No

Supportive documentation for all answers must be attached with this request.

Additional Pertinent Information: *(please include labs, pertinent patient history, etc):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

V010124

 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005