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

Vyvgart, Vyvgart Hytrulo
(efgartigimod alfa-fcab, efgartigimod alfa-fcab; hyaluronidase)

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
☐ Vyvgart Hytrulo 1,008 mg-11,200 unit/5.6 mL (180 mg-2,000 unit/mL) vial
☐ other (please specify):

ICD10:

Directions for use: Dose Quantity: Duration of therapy:

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):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*
Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is your patient a candidate for home infusion? ☐ Yes ☐ No

Does the physician have an in-office infusion site? ☐ Yes ☐ No

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is your patient's diagnosis?

☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ Generalized Myasthenia Gravis (gMG)
☐ other (please specify):

Clinical Information:

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

(if Vyvgart) Will your patient be treated with another Neonatal Fc Receptor Blocker (Rystiggo, Vyvgart Hytrulo), a Complement Inhibitor (Soliris, Ultomiris, Zilbrysq), or a Rituximab Product while receiving this medication? ☐ Yes ☐ No

(if Vyvgart Hytrulo) Will your patient be treated with another Neonatal Fc Receptor Blocker (Rystiggo, Vyvgart), a Complement Inhibitor (Soliris, Ultomiris, Zilbrysq), or a Rituximab Product while receiving this medication? ☐ Yes ☐ No

(if yes to either of the above) Please explain and provide clinical rationale for concurrent use of these drugs

If CIDP:

(if requesting Vyvgart Hytrulo) Which of the following describes the patient's situation?
☐ Currently receiving Vyvgart Hytrulo
☐ Initial therapy

(if requesting Vyvgart Hytrulo and currently receiving) Has the patient had a clinically significant improvement in neurologic symptoms according to the prescriber? Examples of improvement in neurologic symptoms include improvement in disability; nerve conduction study results improved or stabilized; physical examination shows improvement in neurological symptoms, strength, and sensation. ☐ Yes ☐ No

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

(if requesting Vyvgart Hytrulo for initial) Is the diagnosis of Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) supported by electrodiagnostic studies? ☐ Yes ☐ No

(if requesting Vyvgart Hytrulo for initial) Does the patient have a contraindication to intravenous or subcutaneous immune globulin? ☐ Yes ☐ No

(if no contraindication) Has the patient previously received treatment with an intravenous or subcutaneous immune globulin? ☐ Yes ☐ No

(if previously received treatment) Did the patient experience an inadequate efficacy or significant intolerance to an intravenous or subcutaneous immune globulin? ☐ Yes ☐ No

(if requesting Vyvgart Hytrulo for initial) Is this medication being prescribed by, or in consultation with, a neurologist? ☐ Yes ☐ No

If gMG:

(if requesting Vyvgart Hytrulo or Vyvgart Intravenous) Which of the following describes the patient's situation?
☐ Currently receiving Vyvgart Hytrulo (or Vyvgart Intravenous [efgartigimod alfa-fcab intravenous infusion])
☐ Initial therapy

(if requesting Vyvgart Hytrulo and currently receiving) Is the patient continuing to derive benefit from Vyvgart Hytrulo (or Vyvgart Intravenous) according to the prescriber? Examples of derived benefit include reductions in exacerbations of myasthenia gravis; improvements in speech, swallowing, mobility, and respiratory function. ☐ Yes ☐ No

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

(if requesting Vyvgart Intravenous and currently receiving)

Is the patient continuing to derive benefit from Vyvgart Intravenous (or Vyvgart Hytrulo), according to the prescriber? Note: Examples of derived benefit include reductions in exacerbations of myasthenia gravis; improvements in speech, swallowing, mobility, and respiratory function. ☐ Yes ☐ No

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

(if requesting Vyvgart Hytrulo for initial therapy) Is there documentation that the patient has confirmed anti-acetylcholine receptor antibody positive disease? ☐ Yes ☐ No

(if requesting Vyvgart for initial therapy) Was antibody testing performed for this patient? ☐ Yes ☐ No

(if yes) Was the patient found to be positive for anti-acetylcholine receptor antibody (AChR)? ☐ Yes ☐ No

(if requesting Vyvgart for initial therapy) What is the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification?
☐ Class I (pure ocular)
☐ Class II (mild generalized)
☐ Class III (moderate generalized)
☐ Class IV (severe generalized)
☐ Class V (intubation/myasthenic crisis)
☐ unknown

(if requesting Vyvgart Hytrulo for initial therapy) What is the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification?
☐ Class I (pure ocular)
☐ Class II (mild generalized)
☐ Class III (moderate generalized)
☐ Class IV (severe generalized)
☐ Class V (intubation/myasthenic crisis)
☐ unknown

(if requesting Vyvgart for initial therapy) Does the patient have a Myasthenia Gravis Activities of Daily Living (MG-ADL) score of 5 or higher? ☐ Yes ☐ No

(if requesting Vyvgart Hytrulo initial) Does the patient have a Myasthenia Gravis Activities of Daily Living (MG-ADL) score of 5 or higher? ☐ Yes ☐ No

(if requesting Vyvgart OR requesting Vyvgart Hytrulo) Is this medication being prescribed by, or in consultation with, a neurologist? ☐ Yes ☐ No

(if requesting Vyvgart for initial therapy) Is the patient currently receiving pyridostigmine or has the patient received pyridostigmine in the past? ☐ Yes ☐ No

(if requesting Vyvgart and not currently receiving/has received pyridostigmine) 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.

(if requesting Vyvgart and not currently receiving/has received pyridostigmine) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried pyridostigmine, but it didn't work well enough.
☐ The patient tried pyridostigmine, but they had significant intolerance to it.
☐ The patient cannot try pyridostigmine because of a contraindication to this drug.
☐ Other

(if requesting Vyvgart Hytrulo initial) Has the patient received or is the patient currently receiving pyridostigmine? ☐ Yes ☐ No

(if requesting Vyvgart Hytrulo and not received or currently receiving pyridostigmine) Has the patient had an inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine? ☐ Yes ☐ No

(if requesting Vyvgart) for initial therapy) Does the patient have 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, talking, impairment of mobility)? ☐ Yes ☐ No

(if requesting Vyvgart Hytrulo initial) Does the patient have evidence of unresolved symptoms of generalized myasthenia gravis, such as difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity (for example, double vision, talking, impairment of mobility)? ☐ Yes ☐ No

(if requesting Vyvgart) 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: *(including: if the patient is currently on the requested drug [with dates of use] and how they have been receiving it [for example: samples, out of pocket]):*

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:**_____

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