

EFGARTIGIMOD

PRIOR AUTHORIZATION

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

| | | | |
|-----------------------|-------------------|--------------------|-------------------|
| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
| Patient Address: | City, State, Zip: | Patient Telephone: | |
| Member ID Number: | Group Number: | | |

PRESCRIBER/CLINIC INFORMATION

| | | | |
|-------------------|------------------|---------------|---------------|
| Prescriber Name: | Prescriber NPI#: | Specialty: | Contact Name: |
| Clinic Name: | Clinic Address: | | |
| City, State, Zip: | Phone #: | Secure Fax #: | |

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

| | |
|--|---------------------|
| Patient’s Diagnosis: <input type="checkbox"/> Chronic inflammatory demyelinating polyneuropathy (CIDP) <input type="checkbox"/> generalized Myasthenia Gravis (gMG) <input type="checkbox"/> Other (ICD code plus description): _____ | |
| Medication Requested: | Strength: |
| Dosing Schedule: | Quantity per Month: |
| <p>For all requests:</p> <p>1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication(s): _____</p> <p>3. Is the patient’s age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is there support for using the requested agent for the patient’s age for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____</p> <p>4. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is there support for therapy with a higher dose for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____ _____ If no, is there support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____ _____</p> <p>5. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., neurologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>Please continue to the next page.</p> | |

| | | | |
|-----------------------|-------|----|-------------------|
| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
|-----------------------|-------|----|-------------------|

6. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? Yes No
 If no, has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced, metastatic cancer?
 Please note, chart notes are required. Yes No
7. Is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? Yes No
8. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

Please select what the requested agent will be used for and answer any corresponding questions:

Chronic inflammatory demyelinating polyneuropathy (CIDP)

9. Is the patient's disease course progressive or relapsing and remitting for at least 2 months? Yes No
10. Does the patient have progressive or relapsing motor sensory impairment of more than one limb? Yes No
11. Does the patient have electrodiagnostic findings indicating demyelination with at least ONE of the following? Yes No
- 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
12. Has the patient 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)? Yes No
 If yes, please specify therapy tried: _____
 If no, does the patient have an intolerance or hypersensitivity to ONE standard of care therapy (i.e., corticosteroids, immunoglobulins, plasma exchange)? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to ALL standard of care therapies (i.e., corticosteroids, immunoglobulins, plasma exchange)? Yes No
 If yes, please specify FDA labeled contraindication(s): _____

generalized Myasthenia Gravis (gMG)

13. Are there medical records showing the patient has a positive serological test for anti-AChR antibodies? Yes No
14. Does the patient have a Myasthenia Gravis Foundation of America (MGFA) clinical classification class of II-IVb? Yes No
15. Does the patient have a MG-Activities of Daily Living total score of greater than or equal to 5? Yes No
16. Have the patient's current medications been assessed AND any medications known to exacerbate myasthenia gravis (e.g., beta blockers, procainamide, quinidine, magnesium, anti-programmed death receptor-1 monoclonal antibodies, hydroxychloroquine, aminoglycosides) been discontinued? Yes No
 If no, is the discontinuation of the offending agent NOT clinically appropriate? Yes No
 If yes, please provide supporting information _____

Please continue to the next page.

| | | | |
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17. Has the patient required chronic intravenous immunoglobulin (IVIG)? Yes No
 If no, has the patient required chronic plasmapheresis/plasma exchange? Yes No
 If no, has the patient tried and had an inadequate response to at least ONE conventional agent used for the treatment of myasthenia gravis (i.e., corticosteroids, azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide)?
 If yes, please specify agent used: _____
 If no, does the patient have an intolerance or hypersensitivity to ONE conventional agent used for the treatment of myasthenia gravis (i.e., corticosteroids, azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide)? Yes No
 If yes, please explain intolerance/hypersensitivity _____

 If no, does the patient have an FDA labeled contraindication to ALL conventional agents used for the treatment of myasthenia gravis (i.e., corticosteroids, azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide)? Yes No
 If yes, please specify FDA labeled contraindication _____

18. Will the patient be using the requested agent in combination with Rystiggo (rozanolixizumab-noli), Soliris (eculizumab), Bkernv (eculizumab-aeeb), Epysqli (eculizumab-aagh), Ultomiris (ravulizumab-cwvz), Zilbrysq (zilucoplan), or Imaavy (nipocalimab-aahu)? Yes No
 Other

19. Does the patient have an FDA labeled indication for the requested agent and route of administration? Yes No

20. Does the patient have an indication that is supported in compendia for the requested agent and route of administration? (Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI. Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI, DrugDex level 1, 2A, or 2B, or Clinical Pharmacology, Lexi-Drugs evidence level A, peer-reviewed medical literature.) Yes No

21. Are there TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective? Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. Please note, case studies are not acceptable, and journal articles are required. Yes No

For renewal requests:

22. Has the patient had clinical benefit with the requested agent? Yes No

23. Will the patient be using the requested agent in combination with Rystiggo (rozanolixizumab-noli), Soliris (eculizumab), Bkernv (eculizumab-aeeb), Epysqli (eculizumab-aagh), Ultomiris (ravulizumab-cwvz), Zilbrysq (zilucoplan), or Imaavy (nipocalimab-aahu)? Yes No
 If yes, please specify agent: _____

Please fax or mail this form to:
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