

ZILBRYSQ

PRIOR AUTHORIZATION REQUEST

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"/> 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 If yes, is the patient currently stable on the requested agent? Please note, chart notes are required...... <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. 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>5. Will the patient be using the requested agent in combination with any of the following: 1) Bkembv (eculizumab-aeeb), 2) Epysqli (eculizumab-aagh), 3) Imaavy (nipocalimab-aahu) , 4) Rystiggo (rozanolixizumab-noli), 5) Soliris (eculizumab), 6) Ultomiris (ravulizumab-cwvz), 7) Vyvgart (efgartigimod), or 8) Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. 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. _____ _____ _____</p>	
<p>Please continue to the next page.</p>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For generalized Myasthenia Gravis (gMG) requests:

7. Are there medical records showing the patient has a positive serological test for anti-AChR antibodies?..... Yes No
If yes, please submit medical records.
8. Does the patient have a Myasthenia Gravis Foundation of America (MGFA) clinical classification class of II-IVb?..... Yes No
9. Does the patient have a MG-Activities of Daily Living total score of greater than or equal to 6? Yes No
10. Has 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 discontinuation of the offending agent NOT clinically appropriate? Yes No
If yes, please explain clinical rationale: _____
11. 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
If yes, please submit chart notes.
If yes, 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
If yes, 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
12. 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)? Yes No
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: _____

If no, does the patient require chronic intravenous immunoglobulin (IVIG)?..... Yes No
If no, does the patient require chronic plasmapheresis/plasma exchange?..... Yes No

*****Please use the table to answer the following questions and submit chart notes to support the answers. *****

Preferred Agent(s)
Ultomiris (ravulizumab-cwvz)
Rystiggo (rozanolixizumab-noli)
Vyvgart (efgartigimod)
Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)
Epysqli (eculizumab-aagh)

13. Has the patient tried and had an inadequate response to ONE preferred agent?..... Yes No
14. Does the patient have an intolerance, or hypersensitivity to ONE preferred agent? Yes No
15. Does the patient have an FDA labeled contraindication to ALL of the preferred agents? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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16. Was ONE preferred agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No
17. Is ONE preferred agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
18. Are ALL of the preferred agents not in the best interest of the patient based on medical necessity? Yes No
19. Has the patient tried another drug in the same pharmacologic class or with the same mechanism of action as ONE preferred agent and that drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

For renewal requests:

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

Please fax or mail this form to:
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 Eagan, MN 55121
TOLL FREE

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BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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