Prior Authorization Request Form for **efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)**

JOHNS HOPKINS
HEALTH PLANS
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**Fax completed form and applicable progress notes to: (410) 424-4037**

# USFHP Pharmacy Prior Authorization Form

| To be completed by requesting provider | |
|---|---|
| Drug Name: | Strength: |
| Dosage/Frequency (SIG): | Duration of Therapy: |

***Questions?*** Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

**Initial therapy approves for 6 months, renewal approves indefinitely. For renewal of therapy, an initial Tricare prior authorization approval is required.**

**Step 1** **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: _____ Secure Fax #: _____

**Step 2** **Please complete the clinical assessment:**

| | | |
|---|---|---|
| **1. Has the patient received this medication under the TRICARE benefit in the last 6 months?** *Please choose "No" if the patient did not previously have a TRICARE approved PA for Vyvgart Hytrulo.* | ☐ Yes<br>Proceed to question **2** | ☐ No<br>Proceed to question **3** |
| **2. Has the patient's disease severity improved and stabilized to warrant continued therapy?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3. Is the patient 18 years of age or older?** | ☐ Yes<br>Proceed to question **4** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. Is the requested medication prescribed by a neurologist?** | ☐ Yes<br>Proceed to question 5 | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **5. What is the indication or diagnosis?** | ☐ Chronic inflammatory demyelinating polyneuropathy - **Sign and date below**<br>☐ Generalized myasthenia gravis (gMG) that is anti-acetylcholine receptor (AChR) antibody positive - Proceed to question **6** | |

| | | |
|---|---|---|
| **6. Has the patient had insufficient response or intolerance to pyridostigmine?** | ☐ Yes<br>Proceed to question **7** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **7. Has the patient had insufficient response or intolerance to glucocorticoid sparing therapy such as azathioprine, mycophenolate, cyclosporine, or tacrolimus?** | ☐ Yes<br>Proceed to question **8** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **8. Is the patient receiving concomitant neonatal Fc receptor antagonists or other C5 inhibitors with Vyvgart Hytrulo?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**Sign and date below** |

**Step 3** **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[23 May 2025]

| **For Internal Use Only** | |
|---|---|
| ☐ Approved: | Duration of Approval: _____month(s) |
| ☐ Denied: | Authorized By: |
| ☐ Incomplete/Other: | PA#: |
| Date Faxed to MD: | Date Decision Rendered: |