Vyvgart

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Vyvgart SGM 5102-A – 09/2022.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Clinical Criteria Questions:

1. What is the diagnosis?
   - ❑ Generalized myasthenia gravis (gMG)
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #6*
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No
5. Has the patient experienced a positive response to therapy (e.g., improvement in MG-ADL score, changes compared to baseline in Quantitative Myasthenia Gravis (QMG) total score)? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive response to therapy and no further questions.***
   ❑ Yes ❑ No
6. Is the requested drug being used to treat a patient who is anti-acetylcholine receptor (AchR) antibody positive?***ACTION REQUIRED: If Yes, please attach documentation of AchR antibody testing.***
   ❑ Yes ❑ No
7. What is the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification? ***ACTION REQUIRED: Please attach documentation of MGFA clinical classification.***
   - ❑ Class I
   - ❑ Class II
   - ❑ Class III
   - ❑ Class IV
   - ❑ Class V
   - ❑ Unknown
8. What is the patient's score on the MG activities of daily living? ***ACTION REQUIRED: Please attach documentation of MG-ADL score. _____***
9. Is the MG-ADL score at least 50% due to non-ocular symptoms? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation.*** ❑ Yes ❑ No
10. Is the patient on a stable dose of at least one of the following therapies? ***ACTION REQUIRED: Please attach chart notes or medical record documentation.***
    - ❑ Acetylcholinesterase inhibitors (e.g., pyridostigmine)
    - ❑ Steroids (at least 3 months of treatment)
    - ❑ Nonsteroidal immunosuppressive therapy (NSIST) (at least 6 months of treatment) (e.g., azathioprine, mycophenolate mofetil)
    - ❑ None of the above

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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