

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Vyvgart® Hytrulo (efgartigimod alfa/hyaluronidase-qvfc) (Pharmacy)
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Recommended Dosing: SUBQ: 1,000 mg efgartigimod alfa/10,000 units hyaluronidase once weekly.

Quantity Limit: 4 syringes per 28 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Length of Authorization: Initial coverage will be provided for 6 months and may be renewed annually thereafter

- ☐ Member is 18 years of age or older
- ☐ Prescribed by or in consultation with a specialist for CIDP
- ☐ Member has progressive or relapsing and remitting CIDP for > 2 months (submit documentation)

(Continued on next page)

- ☐ Member was determined to have Probable or Definite CIDP according to EFNS/PNS 2010
- ☐ Member has decreased or absent deep tendon reflexes in upper or lower limbs
- ☐ Electrodiagnostic testing indicating demyelination must meet **TWO** of the following:
 - ☐ Partial motor conduction block in at least 2 motor nerves or in 1 nerve plus one other demyelination criterion listed here in at least 1 other nerve
 - ☐ Distal CMAP duration increase in at least 1 nerve plus one other demyelination criterion listed here in at least 1 other nerve
 - ☐ Abnormal temporal dispersion conduction must be present in at least 2 motor nerves
 - ☐ Reduced motor conduction velocity in at least 2 motor nerves
 - ☐ Prolonged distal motor 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
 - ☐ Prolonged F wave latency in at least 2 motor nerves
 - ☐ $\geq 30\%$ amplitude reduction of the proximal negative peak CMAP relative to distal, excluding the posterior tibial nerve, if distal negative peak CMAP $\geq 20\%$ of LLN, in two nerves, or in one nerve + ≥ 1 other demyelinating parameter in ≥ 1 other nerve
- ☐ Member has a baseline CIDP Disease Activity Status (CDAS) score ≥ 2 (**submit documentation**)
- ☐ Members baseline in strength/weakness has been documented using an objective clinical measuring tool (e.g., INCAT, Medical Research Council (MRC) muscle strength (**submit documentation**))
- ☐ Member has tried and failed at least a 3-month trial of immunoglobulin (IG) or plasma exchange therapy (**submit documentation to support inadequate efficacy**)
- ☐ Requested medication will **NOT** be used as maintenance therapy in combination with immunoglobulin or intravenous efgartigimod

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****