2211 Sanders Road, Northbrook, IL 60062 Phone (866) 814-5506

Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}
To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}

Electronically (4-5 **minutes** process time)	Phone (10-15 **minutes** process time)	Fax (24-72 **hours** process time)
CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval. Most requests will not require a fax or phone call. To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.	Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. OR online	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. OR online

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

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 Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}
Patient's ID: {Auth.Member.MemberID}

Date: {System.DateTime.Today}

Patient's Date of Birth: {Auth.Member.MemberBirthDate}

Physician's Name: {Auth.ProviderBilling.Name.Legal}
Specialty: _____
Physician Office Telephone: {Auth.OfficeContactPhoneNumber}

NPI#: {Auth.ProviderBilling.NPI}
Physician Office Fax: {Auth.OfficeContactFaxNumber}

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*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

Clinical Criteria Questions:

What product is being requested? ❑ Vyvgart ❑ Vyvgart Hytrulo

1. What is the patient's diagnosis?
   ❑ Myasthenia gravis
   ❑ Other _____

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

2. What is the ICD-10 code? _____
3. Does the prescriber agree that the patient will be monitored during administration and for one hour after for clinical signs and symptoms of hypersensitivity reactions? ❑ Yes ❑ No
4. Does the patient have an active infection (e.g., urinary tract infection or respiratory tract infection)? ❑ Yes ❑ No
5. Will the requested drug be given concurrently with live vaccines? ❑ Yes ❑ No
6. Is the request for initiation or continuation of treatment with the drug?
   ❑ Initiation, *Skip to #10*
   ❑ Continuation
7. Did the patient experience a decrease of (MG-ADL) total score from pre-treatment baseline of at least 2 points in MG-ADL total score? ❑ Yes ❑ No
8. Has at least 49 days passed since the start of the previous treatment cycle**.** ❑ Yes ❑ No
9. Does the prescribed dose exceed 12 vials per 28 days? ❑ Yes ❑ No *No Further Questions*
10. Does the patient have a positive serologic test for anti-AChR antibodies? ❑ Yes ❑ No
11. Is the disease Myasthenia Gravis Foundation of America (MGFA) clinical classification class II to IV?
    ❑ Yes ❑ No
12. Is there documentation of baseline MG-Activities of Daily Living (MG-ADL) total score ≥ 5 with at least 50% of the score due to non-ocular symptoms? ***ACTION REQUIRED: If yes, please submit supporting documentation.***
    ❑ Yes ❑ No
13. Has the patient had an inadequate treatment response, intolerance, or contraindication to an acetylcholinesterase inhibitor and at least ONE immunosuppressive therapy either in combination or as monotherapy with any of the following?
    a. Azathioprine
    b. Cyclosporine
    c. Mycophenolate mofetil
    d. Tacrolimus
    e. Methotrexate
    f. Cyclophosphamide

    ❑ Yes ❑ No
14. Does the patient have IgG levels of at least 6 g/L? ❑ Yes ❑ No
15. Does the prescribed dose exceed 12 vials per 28 days? ❑ Yes ❑ No

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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