



## Zilbrysq

### CareFirst 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.

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**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

*Please indicate the place of service for the requested drug:*

- Ambulatory Surgical       Home       Off Campus Outpatient Hospital  
 On Campus Outpatient Hospital       Office       Pharmacy

What is the ICD-10 code? \_\_\_\_\_

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

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**Exception Criteria Questions:**

1. The preferred products for your patient's health plan are Ultomiris, Vyvgart, and Vyvgart Hytrulo

Can the patient's treatment be switched to one of the preferred products?

- Yes, Ultomiris, *Please obtain Form for preferred product and submit for corresponding PA.*
- Yes, Vyvgart, *Please obtain Form for preferred product and submit for corresponding PA.*
- Yes, Vyvgart Hytrulo, *Please obtain Form for preferred product and submit for corresponding PA.*
- No, *Continue to Question 2*

2. What is the patient's diagnosis?

- C3 glomerulopathy (C3G), *Skip to Clinical Criteria Questions*
- Immunoglobulin G4-related disease, *Skip to Clinical Criteria Questions*
- Myasthenia Gravis, *Continue to Question 3*
- Primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN), *Skip to Clinical Criteria Questions*
- Other, *Continue to Question 4*

3. Did the patient have a documented inadequate response, intolerable adverse event, or contraindication to all of the preferred products (Ultomiris, Vyvgart, and Vyvgart Hytrulo)?

**Action Required:** *If Yes, attach supporting chart note(s)*

- Yes, *Skip to Clinical Criteria Questions*
- No, *Skip to Clinical Criteria Questions*

4. Did the patient have a documented inadequate response, intolerable adverse event, or contraindication to Ultomiris?

**Action Required:** *If Yes, attach supporting chart note(s)*

- Yes, *Continue to Clinical Criteria Questions*
- No, *Continue to Clinical Criteria Questions*

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**Criteria Questions:**

1. What is the diagnosis?

- Generalized myasthenia gravis (gMG), *Continue to 2*  
 Other, please specify. \_\_\_\_\_, *Continue to 2*

2. Will the requested medication be used in combination with another complement inhibitor (e.g., Soliris, Ultomiris) or neonatal Fc receptor blocker (e.g., Vyvgart, Vyvgart Hytrulo, Rystiggo)?

- Yes, *Continue to 3*  
 No, *Continue to 3*

3. Is this a request for continuation of therapy with the requested medication?

- Yes, *Continue to 4*  
 No, *Continue to 6*

4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

- Yes, *Continue to 5*  
 No, *Continue to 5*

5. Has the patient experienced a positive response to therapy (e.g., improvement in MG-ADL score, MG Manual Muscle Test (MMT), MG Composite)? ***ACTION REQUIRED:*** If Yes, please attach chart notes or medical record documentation supporting positive response to therapy.

- Yes, *No Further Questions*  
 No, *No Further Questions*

6. Is the requested medication being used to treat a patient who is anti-acetylcholine receptor (AChR) antibody positive?

***ACTION REQUIRED:*** If Yes, please attach chart notes or medical record documentation of a positive anti-acetylcholine receptor (AChR) antibody test.

- Yes, *Continue to 7*  
 No, *Continue to 7*

7. What is the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification? ***ACTION***

***REQUIRED:*** Please attach chart notes or medical record documentation of Myasthenia Gravis Foundation of America (MGFA) clinical classification.

- Class I ***ACTION REQUIRED:*** *Submit supporting documentation, Continue to 8*  
 Class II ***ACTION REQUIRED:*** *Submit supporting documentation, Continue to 8*  
 Class III ***ACTION REQUIRED:*** *Submit supporting documentation, Continue to 8*  
 Class IV ***ACTION REQUIRED:*** *Submit supporting documentation, Continue to 8*  
 Class V ***ACTION REQUIRED:*** *Submit supporting documentation, Continue to 8*  
 Unknown, *Continue to 8*

8. What is the patient's score on the MG activities of daily living (MG-ADL)? ***ACTION REQUIRED:*** Please attach chart notes or medical record documentation of MG-ADL score.

- Less than 5 ***ACTION REQUIRED:*** *Submit supporting documentation, Continue to 9*  
 Greater than or equal to 5 ***ACTION REQUIRED:*** *Submit supporting documentation, Continue to 9*

9. Has the patient had an inadequate response or intolerable adverse event to at least two immunosuppressive therapies over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, tacrolimus)? ***ACTION REQUIRED:*** If Yes, please attach chart notes, medical records, or claims history documentation of previous medications tried, including response to therapy.

- Yes, *No Further Questions*  
 No, *Continue to 10*

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10. Has the patient had an inadequate response or intolerable adverse event to at least one immunosuppressive therapy and intravenous immunoglobulin (IVIG) therapy over the course of at least 12 months? ***ACTION REQUIRED:*** If Yes, please attach chart notes, medical records, or claims history documentation of previous medications tried, including response to therapy.

Yes, *No Further Questions*

No, *Continue to 11*

11. Does the patient have a documented clinical reason to avoid therapy with immunosuppressive agents and intravenous immunoglobulin (IVIG)? ***ACTION REQUIRED:*** If Yes, please attach chart notes or medical record documentation of clinical reason to avoid therapy.

Yes, *No Further Questions*

No, *No Further Questions*

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<b>Step Therapy Override 2197-D: Complete if Applicable for the state of Maryland.</b>	Please Circle	
1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
3. Is the alternate drug FDA-approved for the medical condition being treated? <i>If No, No Further Questions</i>	Yes	No
4. Has the prescriber documented in the patient's chart that the requested drug was ordered for the patient in the past 180 days? <i>If No, Skip to 6</i>	Yes	No
5. Has the prescriber documented in the patient's chart that in their opinion the requested drug is effective for the patient's condition? <i>If Yes or No, No Further Questions</i>	Yes	No
6. Is the alternate drug contraindicated or will likely cause an adverse reaction to the patient? <i>If Yes, No Further Questions</i>	Yes	No
7. Is the alternate drug expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen? <i>If Yes, No Further Questions</i>	Yes	No
8. Is the patient stable on the requested drug for the medical condition under consideration? <i>If Yes, No Further Questions</i>	Yes	No
9. Has the patient tried a prescription drug while covered under their current policy or a previous source of coverage, that is in the same pharmacologic class or has the same mechanism of action as the alternate drug and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? <i>No Further Questions</i>	Yes	No

<b>Step Therapy Override 3145-D: Complete if Applicable for the state of Virginia.</b>	Please Circle	
1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
3. Is the alternate drug contraindicated? <i>If Yes, No Further Questions</i>	Yes	No
4. Is the alternate drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen? <i>If Yes, No Further Questions</i>	Yes	No
5. Has the patient tried the alternate drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? NOTE: Pharmaceutical drug samples are not considered trial and failure of a preferred drug. <i>If Yes, No Further Questions</i>	Yes	No
6. Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition? <i>No Further Questions</i>	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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