{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the diagnosis?
   ❑ Generalized myasthenia gravis (gMG) ❑ Other _____
2. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #5*
3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No
4. 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 *No further questions.*
5. 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 ❑ No
6. What is the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification? ***ACTION REQUIRED: Please attach chart notes or medical record documentation of MGFA clinical classification.*** ❑ Class I ❑ Class II ❑ Class III ❑ Class IV ❑ Class V ❑ Unknown
7. What is the patient's score on the MG activities of daily living? ***ACTION REQUIRED: Please attach chart notes or medical record documentation of MG-ADL score.***
   ❑ Less than 6 ❑ Greater than or equal to 6
8. 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
9. 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

10. 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

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date