BlueCross BlueShield Federal Employee Program

VYVGART
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Vyvgart Hytrulo

(efgartigimod alfa and hyaluronidase-qvfc)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Is this request for brand or generic? ❑Brand ❑Generic
2. 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
3. Does the patient have any active infections such as a urinary tract infection or respiratory tract infection? ❑Yes ❑No
4. What is the patient diagnosis?

❑ Chronic inflammatory demyelinating polyneuropathy (CIDP)

a. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have an IgG level of 6 grams per liter or greater? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Have the patient's CIPD symptoms remained stable or improved from baseline? ❑Yes ❑No

❑ Myasthenia Gravis (gMG)

a. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have a positive serologic test for anti-AChR antibodies? ❑Yes ❑No

ii. What is the patient's Myasthenia Gravis Foundation of America (MGFA) Clinical Classification?
Please select answer: ❑Class I ❑Class II ❑Class III ❑Class IV ❑Class V ❑Unknown

iii. Does the patient have a documented score of either the MG-Activities of Daily Living (MG-ADL) or Quantitative Myasthenia Gravis (QMG)? ❑Yes* ❑No

***If YES**, please select answer below and provide the score:

❑ **MG-Activities of Daily Living (MG-ADL)** **Score**: _____

❑ **Quantitative Myasthenia Gravis (QMG)** **Score**: _____

iv. Does the patient have an IgG level of 6 grams per liter or greater? ❑Yes ❑No

v. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to one of the following: acetylcholinesterase inhibitor, azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, or cyclophosphamide? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Have at least 49 days passed since the start of the previous treatment cycle? ❑Yes ❑No

ii. Was the patient's baseline score assessed by the MG-Activities of Daily Living (MG-ADL) or Quantitative Myasthenia Gravis (QMG)? ***Please select answer below:***

❑ **MG-Activities of Daily Living (MG-ADL):** Has the patient's total score decreased by 2 or more points from baseline? ❑Yes ❑No

❑ **Quantitative Myasthenia Gravis (QMG):** Has the patient's total score decreased by 2 or more points from baseline? ❑Yes ❑No

❑ Other ***(please specify):*** _____

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Vyvgart – FEP MD Fax Form Revised 1/1/2026