BlueCross BlueShield
Federal Employee Program

ZILBRYSQ
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					

Zilbrysq

(zilucoplan)

****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. Is the prescriber enrolled in the Zilbrysq REMS program? ❑Yes ❑No
3. Does the patient have a diagnosis of generalized myasthenia gravis (gMG)? ❑Yes ❑No
4. Will Zilbrysq be used in combination with another Prior Authorization (PA) C5 complement inhibitor for generalized myasthenia gravis (gMG) (e.g., Ultomiris (ravulizumab-cwvz), Soliris (eculizumab))? ❑Yes* ❑No

   If YES, please specify the medication: _____
5. 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:

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

   b. What is the patient's MGFA (Myasthenia Gravis Foundation of America) clinical classification? ***Select answer below:***
   ❑Class I ❑Class II to IV ❑Class V ❑Unknown

   c. Does the patient have a documented baseline *MG-Activities of Daily Living (MG-ADL) total score greater than or equal to 6? ❑Yes ❑No
   ***MG-ADL*: http://c.peerview.com/inReview/programs/150204324/downloads/PVI_practiceaids_RMU.pdf**

   d. Has or will the patient be vaccinated against Neisseria meningitidis at least 2 weeks prior to initiating therapy? ❑Yes ❑No*

   ***If NO**, is urgent Zilbrysq therapy indicated for this patient (e.g., the risks of delaying treatment with Zilbrysq outweigh the risk of developing a meningococcal infection)? ❑Yes ❑No

   e. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to an acetylcholinesterase inhibitor? ❑Yes ❑No

   f. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one immunosuppressive therapy either in combination or as monotherapy? Immunosuppressive therapy includes 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:

   a. Is there a documented decrease of the *MG-Activities of Daily Living (MG-ADL) total score from baseline of greater than or equal to 2 points? ❑Yes ❑No
   ***MG-ADL*: http://c.peerview.com/inReview/programs/150204324/downloads/PVI_practiceaids_RMU.pdf**

   b. Has the patient experienced unacceptable toxicity while on Zilbrysq therapy? ❑Yes ❑No

