USFHP Prior Authorization Request Form for **efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Initial therapy approves for 6 months, renewal approves indefinitely. For renewal of therapy, an initial Tricare prior authorization approval is required. Cinical documantation may be required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Vyvgart Hytrulo.*	☐ Yes Proceed to question **2**	☐ No Proceed to question **3**
2. Has the patient's disease severity improved and stabilized to warrant continued therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed by a neurologist?	☐ Yes Proceed to question 5	☐ No **STOP** **Coverage not approved**
5. What is the indication or diagnosis?	☐ Chronic inflammatory demyelinating polyneuropathy - **Sign and date below** ☐ Generalized myasthenia gravis (gMG) that is anti-acetylcholine receptor (AChR) antibody positive - Proceed to question **6**	

6. Has the patient had insufficient response or intolerance to pyridostigmine?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient had insufficient response or intolerance to glucocorticoid sparing therapy such as azathioprine, mycophenolate, cyclosporine, or tacrolimus?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient receiving concomitant neonatal Fc receptor antagonists or other C5 inhibitors with Vyvgart Hytrulo, including but not limited to the following: efgartigimod injection for intravenous use (Vyvgart), eculizumab (Soliris), ravulizumab (Ultomiris), rozanolixizumab (Rystiggo), or zilucoplan (Zilbrysq)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____