US Family Health Plan

Prior Authorization Request Form for

Zilucoplan sodium (Zilbrysq)

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**

Initial approval expires after 6 months, renewal approves for 1 year.

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 Zilbrysq.***	☐ Yes Proceed to question **2**	☐ No Proceed to question **3**
2. Is the patient continuing to derive benefit from Zilbrysq, according to the prescriber (Examples of derived benefit include reductions in exacerbations of myasthenia gravis; improvements in speech, swallowing, mobility, and respiratory function)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Is the patient greater than or equal to 18 years of age?	☐ 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. Does the patient have a documented diagnosis of generalized myasthenia gravis (gMG) that is anti-acetylcholine receptor (AChR) antibody positive?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient known to be muscle-specific tyrosine kinase antibody-positive?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**
7. Has the patient had insufficient response or intolerance to pyridostigmine?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient had insufficient response or intolerance to glucocorticoid sparing therapy such as azathioprine, mycophenolate, cyclosporine, or tacrolimus?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient had insufficient response or intolerance to a neonatal Fc receptor antagonist such as efgartigimod alfa or rozanolixizumab (Rystiggo)?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient been vaccinated against certain encapsulated bacteria (for example, Streptococcus pneumoniae, Neisseria meningitidis types A, C, W, Y, and B, and Haemophilus influenzae type B)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Is the patient receiving neonatal Fc receptor antagonists or other C5 inhibitors with Zilbrysq, including but not limited to the following: eculizumab (Soliris), ravulizumab (Ultomiris), rozanolixizumab (Rystiggo), efgartigimod (Vyvgart), efgartigimod alfa and hyaluronidase (Vyvgart Hytrulo)?	☐ 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 _____