Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name		**Name**
ID Number		**Specialty**
D.O.B.	_____/_____/_____ MM/DD/YYYY ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**VYVGART HYTRULO**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**Contact Person** **Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

❑ Yes ❑ No *If No, a prior authorization is not required through this process*.

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

❑ If primary, continue with questionset.

❑ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Criteria Questions:

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:
     a. What is the patient diagnosis? ***Please select answer below:***
     - ❑ Chronic inflammatory demyelinating polyneuropathy (CIDP)
     - ❑ Myasthenia gravis (gMG)
       i. Does the patient have a positive serologic test for anti-AChR antibodies? ❑Yes ❑No
       ii. What is the patient's MGFA (Myasthenia Gravis Foundation of America) clinical classification?
       ❑Class I ❑Class II to IV* ❑Class V ❑Unknown
       If Class II to IV, does the patient have a documented baseline *MG-Activities of Daily Living (MG-ADL) total score greater than or equal to 5? ❑Yes ❑No
       ***MG-ADL*: http://c.peerview.com/inReview/programs/150204324/downloads/PVI_practiceaids_RMU.pdf**
       iii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to an acetylcholinesterase inhibitor? ❑Yes ❑No
       iv. 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, and cyclophosphamide. ❑Yes ❑No
     - ❑ Other diagnosis, ***please specify***: _____

     b. Does the patient have an immunoglobulin G (IgG) level greater than or equal to 6 grams per liter (g/L)? ❑Yes* ❑No
   - ❑ **YES** – this is **CONTINUATION** of therapy, please answer the following questions:
     a. What is the patient diagnosis? ***Please select answer below:***
     - ❑ Chronic inflammatory demyelinating polyneuropathy (CIDP)
       i. Has the patient's CIDP symptoms remained stable or improved from baseline? ❑Yes ❑No
     - ❑ Myasthenia gravis (gMG)
       i. 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**
       ii. Have at least 49 days passed since the start of the previous treatment cycle? ❑Yes* ❑No
     - ❑ Other diagnosis, ***please specify***: _____

2. Is there an absence of active infections (e.g., urinary tract infection or respiratory tract infection)? ❑Yes ❑No
3. Does the prescriber agree the patient will be monitored during administration and for one hour after for clinical signs and symptoms of hypersensitivity reactions? ❑Yes ❑No

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review **(required)**

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

❑ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	**Physician Signature**	**Date**
Step 2: Checklist	❑ Form Completely Filled Out ❑ Provide chart notes	❑ Attach test results
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox** **1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program** **P.O. Box 312320, Detroit, MI 48231-2320**