Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Vyvgart Hytrulo
(efgartigimod alfa-fcab; hyaluronidase)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:

☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:

☐ Vyvgart Hytrulo 1,008 mg-11,200 unit/5.6 mL (180 mg-2,000 unit/mL) vial
☐ other (please specify):

ICD10:

Directions for use: Dose: Quantity: Duration of therapy:

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):

☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:

Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*
Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is your patient a candidate for home infusion? ☐ Yes ☐ No

Does the physician have an in-office infusion site? ☐ Yes ☐ No

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is your patient's diagnosis?

☐ Generalized Myasthenia Gravis

☐ Chronic inflammatory demyelinating polyneuropathy (CIDP) (Also referred to as chronic relapsing polyneuropathy or chronic inflammatory demyelinating polyradiculoneuropathy)

☐ All other indications

Clinical Information:

Will the requested medication be used with another neonatal Fc receptor blocker, a complement inhibitor, a rituximab product, or Uplizna (inebilizumab-cdon intravenous infusion)? Please Note: Examples of neonatal Fc receptor blockers are Imaavy (nipocalimab-aahu intravenous infusion), Rystiggo (rozanolixizumab-noli subcutaneous infusion) and Vyvgart (efgartigimod alfa-fcab intravenous infusion). Examples of complement inhibitors are eculizumab intravenous infusion (Soliris, biosimilar), Ultomiris (ravulizumab-cwvz intravenous infusion or subcutaneous injection), and Zilbrysq (zilucoplan subcutaneous injection). ☐ Yes ☐ No

(if CIDP or gMG) Is the requested medication prescribed by or in consultation with a neurologist? ☐ Yes ☐ No

(if gMG) Is the patient currently receiving Vyvgart Hytrulo (or Vyvgart Intravenous [efgartigimod alfa-fcab intravenous infusion])? ☐ Yes ☐ No

(if not currently receiving and gMG) Is documentation being provided that the patient has confirmed anti-acetylcholine receptor antibody-positive generalized myasthenia gravis? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if not currently receiving and gMG) Does the patient have Myasthenia Gravis Foundation of America classification of II to IV? ☐ Yes ☐ No

(if not currently receiving and gMG) Does the patient have a Myasthenia Gravis Activities of Daily Living (MG-ADL) score of greater than or equal to 5? ☐ Yes ☐ No

(if not currently receiving and gMG) Has the patient received or is currently receiving pyridostigmine? ☐ Yes ☐ No

(if no) Has the patient had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine? ☐ Yes ☐ No

(if not currently receiving and gMG) Does the patient have evidence of unresolved symptoms of generalized myasthenia gravis? Please Note: Examples of unresolved symptoms include difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity (for example, double vision, talking, impairment of mobility). ☐ Yes ☐ No

(if currently receiving and gMG) Is the patient continuing to derive benefit from Vyvgart Hytrulo (or Vyvgart Intravenous) according to the prescriber? Please Note: Examples of derived benefit include reductions in exacerbations of myasthenia gravis; improvements in speech, swallowing, mobility, and respiratory function. ☐ Yes ☐ No

(if CIDP) Is the patient currently receiving Vyvgart Hytrulo? ☐ Yes ☐ No

(if not currently receiving and CIDP) Was the diagnosis of CIDP supported by electrodiagnostic studies? ☐ Yes ☐ No

(if not currently receiving and CIDP) Has the patient previously received treatment with an intravenous or subcutaneous immune globulin? Please Note: Examples of intravenous or subcutaneous immune globulin include: Gammagard Liquid, Gammaked, Gamunex-C, Panzyga, Privigen, Hizentra, and HyQvia. ☐ Yes ☐ No

(if yes) Has the patient had inadequate efficacy or significant intolerance to an intravenous or subcutaneous immune globulin? Please Note: Examples of intravenous or subcutaneous immune globulin include: Gammagard Liquid, Gammaked, Gamunex-C, Panzyga, Privigen, Hizentra, and HyQvia. ☐ Yes ☐ No

(if not previously treated with IV/SC IG OR no inadequate efficacy or intolerance and CIDP) Does the patient have a contraindication to intravenous or subcutaneous immune globulin? Please Note: Examples of intravenous or subcutaneous immune globulin include: Gammagard Liquid, Gammaked, Gamunex-C, Panzyga, Privigen, Hizentra, and HyQvia. ☐ Yes ☐ No

(if currently receiving and CIDP) Has the patient had a clinically significant improvement in neurologic symptoms, according to the prescriber? Please Note. Examples of improvement in neurologic symptoms include improvement in disability: nerve conduction study results improved or stabilized; physical examination shows improvement in neurological symptoms, strength, and sensation. ☐ Yes ☐ No

Additional Pertinent Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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