Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Vyvgart 20 mg/mL intravenous solution
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Requested Quantity Per Rx – Amount:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____

(*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Generalized myasthenia gravis (gMG)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q4: Does the member have documentation of positive clinical response to therapy? (Check only one that apply)

[ ] Yes (please provide supporting documents) _____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q5: Will the requested medication be administered at 10mg/kg as an intravenous infusion over one hour once weekly for 4 weeks? (Check only one that apply)

[ ] Yes

[ ] No

Q6: Will the requested medication be administered at 1200 mg per infusion over one hour once weekly for 4 weeks in member weighing 120 kg or more? (Check only one that apply)

[ ] Yes

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q7: What is the member's diagnosis? (Check only one that apply)

[ ] Generalized myasthenia gravis (gMG)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q8: Is the member anti-acetylcholine receptor (AChR) antibody positive? (Check only one that apply)

[ ] Yes (please provide supporting documents) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q9: Is the member on a stable dose of at least one of the following therapies for the treatment of gMG prior to administration of requested medication? (Check only one that apply)

[ ] Acetylcholinesterase (AChE) inhibitors (e.g., pyridostigmine) (please specify the drug names and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] Steroids (e.g., prednisone) (please specify the drug names and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] Non-steroidal immunosuppressive therapies (NSISTs) (e.g., azathioprine, cyclosporine, cyclophosphamide) (please specify the drug names and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q10: Will the requested medication be administered at 10mg/kg as an intravenous infusion over one hour once weekly for 4 weeks? (Check only one that apply)

[ ] Yes

[ ] No

Q11: Will the requested medication be administered at 1200 mg per infusion over one hour once weekly for 4 weeks in member weighing 120 kg or more? (Check only one that apply)

[ ] Yes

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q12: Is the reqeusted medication prescribed by or in consultation with a neurologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	