(Revised 10/2023)

blue of california

FEP PPO PRESCRIPTION DRUG PRIOR AUTHORIZATION Vyvgart J9332

Plan/Medical Group Name: Blue Shield of California **Plan Phone#: (800) 633-4581**

☐ **Non-Urgent-** The Federal Employee Program has a **15 day turn-around time on medications that requires Prior Authorization** according to the Blue Cross Blue Shield Service Benefit Plan. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information **FAX TO: 844-224-0226**

☐ **Urgent Request-** Please note, scheduling issues do not meet the definition of Urgent. ***Definition of an Urgent Request:*** An imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision making might seriously jeopardize the life or health of the member. **FAX TO: 844-224-0226**

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): ______ Weight (lb/kg): _	Allergies:
Patient's Authorized Representative (if applicable):	Authorized Representative Phone Number:		

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):	Office Contact Person:		
NPI Number (individual):	Phone Number:		
DEA Number (if required):	Fax Number (in HIPAA compliant area):		
Email Address:			

Medication / Medical and Dispensing Information

Medication Name and HCPCS or CPT Code:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:______________________ Prior Auth Number (if known):______________________
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration: ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location: ☐ Physician's Office ☐ Patient's Home ☐ Long Term Care ☐ Ambulatory Infusion Center
☐ Outpatient Hospital Care ☐ Home Care Agency ☐ Other (explain):

PRESCRIPTION DRUG PRIOR AUTHORIZATION

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization.

1. Has the patient tried any other medications for this condition? YES (if yes, complete below) NO

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances or required under state and federal laws.

Attachments

Initiation of treatment:

1. Patient is 18 or older ☐Yes☐No
2. Diagnosis is Myasthenia Gravis ☐Yes☐No
   - a. Positive serologic test for anti-AChR antibodies ☐Yes☐No
   - b. Myasthenia Gravis Foundation of America (MGFA) Clinical Classification Class II to IV ☐Yes☐No
   - c. Documented baseline MG-Activities of Daily Living (MG-ADL) total score ≥ 5 with at least 50% of the score due to non-ocular symptoms (https://solirisgmg.com/Content/solirisgmg_com/assets/pdf/MG_ADL_Assessment.pdf) ☐Yes☐No
   - d. Patient has had an inadequate treatment response, intolerance, or contraindication to acetylcholinesterase inhibitor and at least ONE immunosuppressive therapy either in combination or as monotherapy, such as: i. azathioprine ii. cyclosporine iii. mycophenolate mofetil iv. tacrolimus v. methotrexate vi. Cyclophosphamide ☐Yes☐No
   - e. IgG level ≥ 6 grams per liter (g/L) ☐Yes☐No
   - f. Prescriber agrees that the patient will be monitored during administration and for one hour after for clinical signs and symptoms of hypersensitivity reactions ☐Yes☐No
   - g. Absence of active infection (e.g., urinary tract infection or respiratory tract infection) ☐Yes☐No
   - h. Plan to receive live vaccines ☐Yes☐No

Renewal of treatment:

1. Patient is 18 or older ☐Yes☐No
2. Diagnosis is Myasthenia Gravis ☐Yes☐No

a. Decrease of MG-ADL total score from baseline of ≥ 2 points ☐Yes☐No (https://solirisgmg.com/Content/solirisgmg_com/assets/pdf/MG_ADL_Assessment.pdf)
b. At least 49 days have passed since the start of the previous treatment cycle ☐Yes☐No
c. Prescriber agrees that the patient will be monitored during administration and for one hour after for clinical signs and symptoms of hypersensitivity reactions ☐Yes☐No
d. Absence of active infection (e.g., urinary tract infection or respiratory tract infection) ☐Yes☐No

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 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 or Electronic I.D. Verification:______________________**Date**:________________________________

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer:_________________ Date/Time of Decision______________
Fax Number (________)____________________

Approved Denied Comments/Information Requested: ____