Acentra HEALTH

Myasthenia Gravis
Prior Authorization Form

Fax completed form to:
855-207-0250
For questions regarding this prior authorization, call
866-773-0695

ND Medicaid requires that members receiving a prescription for non-preferred medications meet specific coverage criteria found at https://ndmedicaid.acentra.com/ndpdl/

Member Name	Member Date of Birth	Member Medicaid ID Number	
Prescriber Name	Prescriber/Rendering NPI	Billing NPI *(medical billing only)*	
Address	City	State	Zip Code
Specialist involved in therapy	Telephone Number	Fax Number	
Diagnosis for this request: ☐ Off-label		Member Weight (kg)	
Requested Drug, Strength, and Directions:		**Dosage Form (e.g., tablet):**	

SECTION A: QUALIFICATIONS FOR COVERAGE

1. Myasthenia Gravis Foundation of American (MGFA) classification: _____
2. The member's serology is positive for (select all that apply):
   - ☐ **Anti-AChR Antibody** – *Proceed to next question*
   - ☐ **MuSK Positive** – *Proceed to Section B (skip question 3)*
3. Is the request for bridge therapy?
   - ☐ NO – *Proceed to Section B*
   - ☐ YES – Provide clinical justification as to why the member is unable to use glucocorticoids – *You do not need to complete remainder of form*:

SECTION B: PREVIOUS MEDICATION TRIALS

4. Has the member required chronic intravenous immunoglobulin (IVIG) or chronic plasmapheresis/plasma exchange (i.e., at least every 3 months over 12 months without symptom control)?
   - ☐ NO – *Proceed to Section C (skip questions 4a and 4b)*
   - ☐ YES – *Proceed to next question*

4a. Was there a 12-month trial (total duration) of immunosuppressive therapies during the IVIG or plasma exchange (select all that apply and provide trial dates/duration)?

- ☐ Azathioprine _____
- ☐ Cyclosporine _____
- ☐ Mycophenolate mofetil _____
- ☐ Tacrolimus _____
- ☐ Other: _____ _____

4b. Was there a 90-day trial or recommended cycle duration during the IVIG or plasma exchange (select all that apply and provide trial dates/duration)?

- ☐ Rituximab _____
- ☐ Ultomiris _____
- ☐ Vyvgart or Rystiggo _____

SECTION C: ASSESSMENT & OUTCOMES MEASURES	Baseline Result and Date	Current Result and Date
Myasthenia Gravis-specific Activities of Daily Living (MG-ADL) – Total Score		
MG-ADL – Non-Ocular Symptoms Score		
Exacerbation rate		

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the member*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*