TRICARE Prior Authorization Request Form for
zilucoplan sodium **(Zilbrysq)**

JOHNS HOPKINS
HEALTH PLANS
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**FAX Completed Form and Applicable Progress Notes to: (410) 424-4037**

# USFHP Pharmacy Prior Authorization Form

| To be completed by Requesting provider | |
|---|---|
| Drug Name: | Strength: |
| Dosage/Frequency (SIG): | Duration of Therapy: |

***Questions?*** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Initial approval expires after 6 months, renewal approves for 1 year. For renewal of therapy, an initial Tricare prior authorization approval is required.

**Step 1** **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID #: _____ Phone #: _____
Date of Birth: Secure Fax #:

**Step 2** **Please complete the clinical assessment:**

| | | |
|---|---|---|
| **1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Zilbrysq.*** | ☐ Yes<br>Proceed to question **2** | ☐ No<br>Proceed to question **3** |
| **2. Is the patient continuing to derive benefit from Zilbrysq, according to the prescriber (Examples of derived benefit include reductions in exacerbations of myasthenia gravis; improvements in speech, swallowing, mobility, and respiratory function)?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3. Is the patient greater than or equal to 18 years of age?** | ☐ Yes<br>Proceed to question **4** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. Is the requested medication prescribed by a neurologist?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |

| | | |
|---|---|---|
| **5. Does the patient have a documented diagnosis of generalized myasthenia gravis (gMG) that is anti-acetylcholine receptor (AChR) antibody positive?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **6. Is the patient known to be muscle-specific tyrosine kinase antibody-positive?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **7** |
| **7. Has the patient had insufficient response or intolerance to pyridostigmine?** | ☐ Yes<br>Proceed to question **8** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **8. Has the patient had insufficient response or intolerance to glucocorticoid sparing therapy such as azathioprine, mycophenolate, cyclosporine, or tacrolimus?** | ☐ Yes<br>Proceed to question **9** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **9. Has the patient had insufficient response or intolerance to a neonatal Fc receptor antagonist such as efgartigimod alfa or rozanolixizumab (Rystiggo)?** | ☐ Yes<br>Proceed to question **10** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **10. Has the patient been vaccinated against certain encapsulated bacteria (for example, Streptococcus pneumoniae, Neisseria meningitidis types A, C, W, Y, and B, and Haemophilus influenzae type B)?** | ☐ Yes<br>Proceed to question **11** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **11. Is the patient receiving neonatal Fc receptor antagonists or other C5 inhibitors with Zilbrysq, including but not limited to the following: eculizumab (Soliris), ravulizumab (Ultomiris), rozanolixizumab (Rystiggo), efgartigimod (Vyvgart), efgartigimod alfa and hyaluronidase (Vyvgart Hytrulo)?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**Sign and date below** |

**Step 3**

**I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[ 14 August 2024]

| **For Internal Use Only** | |
|---|---|
| ☐ Approved: | Duration of Approval: _____month(s) |
| ☐ Denied: | Authorized By: |
| ☐ Incomplete/Other: | PA#: |
| Date Faxed to MD: | Date Decision Rendered: |