Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Zilbrysq (zilucoplan) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Zilbrysq (zilucoplan)** for **Commercial, Exchange, FEHB (Federal), MD Medicaid,** and **VA Medicaid** plans**.** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Is the prescriber a Neurologist?
   □ No □ Yes

2. Is the patient ≥18 years of age?
   □ No □ Yes

3. Does the patient have a diagnosis of generalized myasthenia gravis (gMG)?
   □ No □ Yes

4. Is there a confirmed positive serological test for anti-acetylcholine receptor (AChR) antibodies?
   □ No □ Yes

5. Does the patient meet ONE of the following criteria?
   - No history of thymoma or thymic neoplasm
   - History of thymoma and has had a thymectomy that was completed over 3 months ago

   □ No □ Yes

6. Is the patient's Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥5?
   □ No □ Yes

7. Is the patient currently taking, or has severe intolerance or contraindication to, pyridostigmine for symptomatic management?
   □ No □ Yes

8. Has the patient tried a corticosteroid at maximum tolerated dose for at least 6 months, or has a contraindication to corticosteroid therapy?
   □ No □ Yes

9. Has the patient tried and failed, or has contraindication to chronic IV immunoglobulin (IVIG)?
   □ No □ Yes

<u>If patient is using for CHRONIC therapy:</u>

10. Has the patient had a trial of at least **TWO oral non-steroidal immunosuppressive therapies** for the duration indicated, unless intolerant/contraindicated?
    - <u>First line:</u>
      i. Azathioprine for at least 12 months
      □ No □ Yes

      ii. Mycophenolate for at least 12 months
      □ No □ Yes

    - <u>Alternative agents:</u>
      i. Cyclosporine for at least 6 months

□ No □ Yes

ii. Tacrolimus for at least 12 months
□ No □ Yes

11. Has the patient had a trial of preferred biologics (e.g., KP-preferred rituximab biosimilar* for at least 6 months)?
□ No □ Yes

12. Has the patient tried and failed, or has a contraindication to ALL of the following?
    - Efgartigimod (Vyvgart)
    - Ravulizumab (Ultomiris)
    - Eculizumab-aagh (Epysqli)

□ No □ Yes

If patient is using for BRIDGE therapy:

13. Does the patient have documented non-responsiveness to ALL of the following as bridge therapy?
    - IVIG
    - Efgartigimod (Vyvgart)
    - Ravulizumab (Ultomiris)
    - Eculizumab-aagh (Epysqli)

□ No □ Yes

**Note: Riabni is the KP-preferred rituximab biosimilar*

For continuation of therapy, please respond to additional questions below. New members who were initiated on therapy outside of Kaiser, who have not been reviewed previously, must meet all above Clinical Criteria.

1. If first renewal: Is there documented improvement of at least 2 point on the MG-ADL?
□ No □ Yes

2. For subsequent renewals after the first renewal:
    - If using for **CHRONIC** therapy: Is there documented maintenance of stable MG-ADL score OR documented beneficial effect from therapy during Neurology follow-up in the last 12 months?

□ No □ Yes

- If using for **BRIDGE** therapy: Does provider confirm that the medication can be discontinued after 12 months of therapy?
    - *Note: it takes 12-24 months for slower acting immunotherapies (e.g., azathioprine, mycophenolate) to take effect*

□ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**