

**PRIOR AUTHORIZATION REQUEST FORM**

**RUZURGI®**

**For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.**

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

*Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.*

**Product being requested:**  Ruzurgi® (amifampridine)

Dosing/Frequency: \_\_\_\_\_

**If the request is for reauthorization, proceed to reauthorization section.**

Questions	Yes	No	Comments/Notes
1. Is the requesting prescriber a neurologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the following diagnosis been ruled out: <ul style="list-style-type: none"> <li>• Myasthenia gravis</li> <li>• Parkinsonism</li> <li>• Peripheral neuropathy</li> <li>• Myopathy</li> <li>• Lumbar spinal stenosis</li> <li>• Psychologic issues</li> <li>• Amyotrophic lateral sclerosis</li> <li>• Guillain-Barre syndrome</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the diagnosis of Lambert-Eaton Myasthenic Syndrome been confirmed with the following tests: <ul style="list-style-type: none"> <li>• Presence of antibodies to P/Q type voltage-gates calcium channels in serum</li> <li>• Single fiber electromyography</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member experiencing moderate to severe weakness?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member been screen for malignancy (particularly small cell lung cancer)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. If malignancy is present, does the member meet one of the following: <ul style="list-style-type: none"> <li>• Underlying malignancy has been treat for at least 3 months</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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<ul style="list-style-type: none"> <li>Member has severe LMS symptoms and underlying malignancy is currently being treated</li> <li>The member's malignancy is unable to be treated</li> </ul>			
7. Has the member's medication list been reviewed for any therapies that could aggravate or induce myasthenia (antibiotics, cardiovascular medications, neurological and psychoactive medications, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does documentation show a clinically meaningful response to therapy demonstrating improvement of disease and/or updated results of a single fiber electromyography?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Was the member's initial malignancy screening negative? <ul style="list-style-type: none"> <li>If yes, go to question 5.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation of initial screening and recent screening</b>
5. Has a chest CT scan been done within the past 6 months OR has malignancy been ruled out after at least 2 years of CT scan surveillance?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation of initial screening and recent screening</b>
<b>What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.</b>			
Additional information:			
Physician Signature:			

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Policy PHARM- 084  
 Origination Date: 09/04/2019  
 Reviewed/Revised Date: 10/28/2020  
 Next Review Date: 10/28/2021  
 Current Effective Date: 11/01/2020

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