Rystiggo® (rozanolixizumab-noli) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment, start date: ____/____/____ ☐ Continuation of therapy, date of last treatment: ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	E-mail:	
Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms		Allergies:		

B. INSURANCE INFORMATION

Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #:

Medicaid: ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Neurologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ FAX: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Rystiggo (rozanolixizumab-noli) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*).

Primary ICD Code: _____ **Other ICD Code**: _____

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For Initiation Requests (clinical documentation required):

Generalized myasthenia gravis (gMG)

☐ Yes ☐ No Is the requested drug being used to treat a patient who is anti-acetylcholine receptor (AchR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive?

Please indicate the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification:
Please select: ☐ Class I ☐ Class II ☐ Class III ☐ Class IVa ☐ Class IVb ☐ Class V ☐ Unknown

Please indicate the patient's MG Activities of daily living (MG-ADL) score: _____

☐ Yes ☐ No Was at least 3 points of the MG activities of daily living (MG-ADL) from non-ocular symptoms?

☐ Yes ☐ No Is the patient on a stable dose of at least one of the following: acetylcholinesterase inhibitors (e.g., pyridostigmine), steroids (at least 1 month of treatment), or nonsteroidal immunosuppressive therapy (NSIST) (at least 6 months of treatment) (e.g., azathioprine, mycophenolate mofetil)?

For Continuation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

☐ Yes ☐ No Has the patient experienced a positive response to therapy (e.g., improvement in MG-ADL score, changes compared to baseline in Quantitative Myasthenia Gravis [QMG] total score)?

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.