Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Imaavy Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)497-0905
F. (609)228-9798 Attn: Idyllic Infusion Coordinator

Is this a Continuation of Care or a new start to the medication?

❒ Continuation of Care (Provide documentation of last administration) ❒ New Rx

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI **Tax ID#**	**Name:** **NPI:** **Tax ID#**
Fax Number	
Practice Contact (Name/Phone number)	
Email of Contact	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: **Weight in lbs:**	
Insurance(s): include copies of front and back	
Preferred Treatment Location	❒ Voorhees ❒ Moorestown ❒ Wall/Manasquan ❒ Sewell ❒ Hamilton ❒ Galloway

	❒ Haddon Heights
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

Diagnosis:

❒ G70.01 Myasthenia Gravis with (acute) exacerbation
❒ G70.00 Myasthenia Gravis without (acute) exacerbation
❒ Other: _____

The following information is required for Imaavy prior authorization:

- Does the patient have Generalized Myasthenia Gravis? ❒ YES ❒ NO
    - (if no) Please provide the patient's diagnosis or reason for treatment.
      _____

- (if myasthenia gravis) Is the requested medication being prescribed by or in consultation with a neurologist? ❒ YES ❒ NO

- Is/Will this medication be used concomitantly with another Neonatal Fc Receptor Blocker (examples are Rystiggo, Vyvgart, and Vyvgart Hytrulo, a Complement Inhibitor (examples are eculizumab intravenous infusion [Soliris, biosimilars], Ultomiris [ravulizumab-cwvz intravenous infusion], and Zilbrysq [zilucoplan subcutaneous injection]), or a Rituximab Product? ❒ YES ❒ NO

- (if myasthenia gravis) Is this a request for initial therapy or is the patient currently receiving the requested medication? ❒ Initial therapy ❒ Currently receiving Imaavy

- (if currently receiving) Is the patient continuing to derive benefit from Imaavy, according to the prescriber? ❒ YES ❒ NO

- (if initial therapy) Is documentation being provided that the patient has confirmed anti-acetylcholine receptor antibody-positive generalized myasthenia gravis? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ❒ YES ❒ NO

- (if initial therapy, not confirmed anti-acetylcholine receptor antibody-positive) Is documentation being provided that the patient has confirmed anti-muscle-specific tyrosine kinase antibody-positive generalized myasthenia gravis? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. Medical

documentation specific to your response to this question must be attached to this case or your request could be denied. ❒ YES ❒ NO

- (if initial therapy) Has the patient previously received or are they currently receiving pyridostigmine? ❒ YES ❒ NO
- (if no) Has the patient had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine?❒ YES ❒ NO
- (if initial therapy) Does the patient have evidence of unresolved symptoms of generalized myasthenia gravis? Notes: Examples of unresolved symptoms include difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity (for example, double vision, talking, impairment of mobility). ❒ YES ❒ NO
- (if myasthenia gravis) Does the patient have a Myasthenia Gravis Foundation of America classification of II to IV? ❒ YES ❒ NO
- (if yes) Does the patient have a Myasthenia Gravis Activities of Daily Living (MG-ADL) score of 6 or higher? ❒ YES ❒ NO

PLEASE NOTE:

- Please include a copy of RX to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required.
  - ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
  - *OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS*
  - *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- **!! IMPORTANT !!** *Please notify our office if the medication is discontinued.*

❒ Patient has been educated by the ordering provider on medication.

Ordering Provider Signature: _____