

AGAMREE EMFLAZA PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Please select the patient’s diagnosis:

- Duchenne Muscular Dystrophy (DMD)
- Other (ICD code, plus description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. What is the patient’s weight? _____ (kg)
2. Is the patient currently treated with the requested agent? Yes No
 If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.** Yes No
3. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify FDA labeled contraindications: _____

4. Is the patient’s age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, is there support for using the requested agent for the patient’s age for the requested indication? Yes No
 If yes, please provide supporting information: _____

5. Can the requested quantity (dose) be achieved with a lower quantity of any combination of the four Emflaza tablet strengths? Yes No
 If no, please explain: _____

6. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., pediatric neurologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
-----------------------	-------	----	-------------------

For Paroxysmal Nocturnal Hemoglobinuria (PNH) requests:

- 7. Are there lab tests that confirm the patient's diagnosis by flow cytometry with at least 2 independent flow cytometry reagents on at least 2 cell lineages (e.g., RBCs and WBCs) demonstrating that the patient's peripheral blood cells are deficient in glycosylphosphatidylinositol (GPI) - linked proteins? Please note, lab tests are required. **Please note, medical records are required.** Yes No
- 8. Will the patient be using the requested agent in combination with Soliris (eculizumab), Bkembv (eculizumab-aeeb), or Epysqli (eculizumab-aagh)? **If yes, lab tests are required** Yes No
- 9. Will the patient be using the requested agent in combination with Soliris (eculizumab), Bkembv (eculizumab-aeeb), or Epysqli (eculizumab-aagh)? Yes No
 If yes, please specify agent: _____
 If yes, Will the patient continue to use Soliris, Bkembv, or Epysqli for the first 4 weeks after starting the requested agent, AND then Soliris, Bkembv, or Epysqli will be discontinued? Yes No
- 10. Will the patient be using the requested agent in combination with Fabhalta (iptacopan), Ultomiris (ravulizumab-cwvz), or Piasqy (crovalimab-akkz)? Yes No

For Complement 3 glomerulopathy (C3G) and Immune-complex membranoproliferative glomerulonephritis (IC-MPGN)

- 11. Will the patient be using the requested agent in combination with Fabhalta (iptacopan)? Yes No
- 12. Has the patient's diagnosis been confirmed by a kidney biopsy? Yes No
- 13. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? Yes No
 If no, Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer?
Please note, chart notes required.? Yes No
- 14. Is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? Yes No
- 15. Has the patient had improvements or stabilization with the requested agent as indicated by a decrease baseline (prior to treatment with the requested agent) of urine protein-to-creatinine (UPCR) ratio **or** a decrease from baseline (prior to treatment with the requested agent) in proteinuria?..... Yes No
 If yes, please explain efficacy/improvement: _____

- 16. Is the patient currently treated with a maximally tolerated angiotensin-converting-enzyme inhibitor (ACEi, e.g., benazepril, lisinopril) or angiotensin II blocker (ARB, e.g., losartan), or a combination medication containing an ACEi or ARB within the past 90 days? Yes No
 If yes, please specify agent: _____
 If yes, Will the patient continue maximally tolerated ACEi, or ARB, or a combination medication containing an ACEi or ARB therapy in combination with the requested agent?..... Yes No
 If no, Will the patient continue maximally tolerated ACEi, or ARB, or a combination medication containing an ACEi or ARB therapy in combination with the requested agent?..... Yes No
 If yes, please explain intolerance/hypersensitivity/contraindication: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>17. Does the patient have a urine protein-to-creatinine ratio (UPCR) greater than 0.88 g/g? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">If yes, please specify UPCR lab value: _____</p> <p style="padding-left: 40px;">If no, Does the patient have proteinuria greater than 1.0 g/day? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">If yes, please specify proteinuria lab value: _____</p> <p>18. Is the patient's eGFR greater than or equal to 30 mL/min/1.73 m²? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">If yes, please specify eGFR lab values: _____</p> <p>19. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). Please note, documentation may be required: _____</p> <p>_____</p> <p>_____</p>			
<p>For renewal requests:</p> <p>20. Has the patient improvements or stabilization with the requested agent (e.g., improved strength, timed motor function, pulmonary function; reduced need for scoliosis surgery)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For Paroxysmal Nocturnal Hemoglobinuria (PNH) requests:</p> <p>21. Do medical records show the patient has had improvements or stabilization with the requested agent (e.g., decreased requirement of RBC transfusions, stabilization/improvement of hemoglobin, reduction of lactate dehydrogenase [LDH], stabilization/improvement of symptoms)? Please note, medical records are Required. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Will the patient be using the requested agent in combination with Fabhalta (iptacopan), Soliris (eculizumab), Bkemb (eculizumab-aeeb), Epysqli (eculizumab-aagh), Ultomiris (ravulizumab-cwvz), or Piasky (crovalimab-akkz)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121 TOLL FREE</p>		<p>CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p>	
<p>Phone: BCBSIL: 800.285.9426 BCBSMT: 888.723.7443 BCBSNM: 800.544.1378 BCBSOK: 800.991.5643 BCBSTX: 800.289.1525</p>		<p>Fax: 877.243.6930</p>	