

FABHALTA

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

Patient’s Diagnosis: <input type="checkbox"/> Paroxysmal nocturnal hemoglobinuria (PNH) <input type="checkbox"/> Primary immunoglobulin A nephropathy (IgAN) <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<p>For all requests:</p> <p>1. Is the patient currently being treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Does the patient have any FDA labeled contraindications to the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____</p> <p>3. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., hematologist, nephrologist) or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Is the patient’s age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is there support for using the requested agent for the patient’s age for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____</p> <p>5. Will the patient be using the requested agent in combination with Empaveli (pegcetacoplan), Soliris (eculizumab), Bkernv (eculizumab-aeab), Epysqli (eculizumab-aagh), Ultomiris (ravulizumab-cwvz), or Piasky (crovalimab-akkz)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. 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>Please continue to the next page.</p>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For Paroxysmal Nocturnal Hemoglobinuria (PNH) requests:

7. Are there lab tests showing the patient's diagnosis been confirmed 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? Yes No

For Primary Immunoglobulin A nephropathy (IgAN) requests:

8. Has the patient's diagnosis been confirmed by kidney biopsy? Yes No

9. Does the patient have a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g? Yes No
If yes, please specify UPCR level: _____

10. Is the patient's eGFR greater than or equal to 30 mL/min/1.73 m²? Yes No

11. Has the patient tried and had an inadequate response after at least a 3-month duration of therapy 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? Yes No

If no, does the patient have an intolerance or hypersensitivity to an ACEi or ARB, or a combination medication containing an ACEi or ARB? Yes No

If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to ALL ACEi or ARB? Yes No

If yes, please specify FDA labeled contraindication: _____

12. Has the patient tried and had an inadequate response after a 6-month course of glucocorticoid therapy (e.g., methylprednisolone, prednisolone, prednisone)? Yes No

If no, does the patient have an intolerance or hypersensitivity to a glucocorticoid therapy? Yes No

If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to ALL glucocorticoid therapies? Yes No

If yes, please specify FDA labeled contraindication: _____

If no, Is there support that glucocorticoid therapy is NOT appropriate for the patient? Yes No

If yes, please provide supporting information: _____

13. Will the patient continue on standard of care IgAN therapy (e.g., ACEi, ARB, SGLT2, aliskiren)? Yes No

For renewal requests:

14. Has the patient had clinical benefit with the requested agent? Yes No

For Paroxysmal Nocturnal Hemoglobinuria (PNH) requests:

15. Are there medical records showing 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.** Yes No

For Primary Immunoglobulin A nephropathy (IgAN) requests:

16. Has the patient had improvements or stabilization with the requested agent as indicated by ONE of the following:

1) Decrease from baseline (prior to treatment with the requested agent) of urine protein-to-creatinine ratio (UPCR),

2) Decrease from baseline (prior to treatment with the requested agent) of proteinuria? Yes No

Please fax or mail this form to:

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TOLL FREE

Phone:

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