

**VANRAFIA**  
**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](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://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 diagnosis: <input type="checkbox"/> Primary immunoglobulin A nephropathy (IgAN) <input type="checkbox"/> Other (ICD code and description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

**For all requests:**

- Is the patient currently treated with the requested agent?.....  Yes  No
- Does the patient have any FDA labeled contraindications to the requested agent?.....  Yes  No  
 If yes, please specify FDA labeled contraindications: \_\_\_\_\_
- Is the patient's age within FDA labeling for the requested indication for the requested agent?.....  Yes  No  
 If no, please provide support for using the requested agent for the patient's age for the requested indication: \_\_\_\_\_
- Is the prescriber a specialist in the area of the patient's diagnosis (e.g., nephrologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis? .....  Yes  No
- Was the patient's diagnosis confirmed by kidney biopsy?.....  Yes  No
- Does the patient have a urine-protein-to-creatinine ratio (UPCR) greater than or equal to 0.44 g/g? .....  Yes  No  
 If yes, please specify: \_\_\_\_\_  
 If no, does the patient have a proteinuria greater than or equal to 0.5 g/day? .....  Yes  No  
 If yes, please specify: \_\_\_\_\_
- Is the patient's eGFR greater than or equal to 30 mL/min/1.73 m<sup>2</sup>? .....  Yes  No  
 If yes, please specify: \_\_\_\_\_
- 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:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>9. Has the patient tried and had an inadequate response after at least a 3-month duration of therapy with 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?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, does the patient have an intolerance or hypersensitivity to an ACEi or ARB, or a combination medication containing an ACEi or ARB?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please explain intolerance/hypersensitivity: _____</p> <p>_____</p> <p>If no, does the patient have an FDA labeled contraindication to ALL ACEi and ARB? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please specify FDA labeled contraindication: _____</p> <p>_____</p>			
<p><b>For renewal requests:</b></p> <p>10. 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 (UPCR) ratio, or 2) decrease from baseline (prior to treatment with the requested agent) in proteinuria?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please specify improvement/stabilization: _____</p> <p>_____</p>			
<p><b>Please fax or mail this form to:</b>  Prime Therapeutics LLC  Clinical Review Department  2900 Ames Crossing Road Suite 200  Eagan, MN 55121</p> <p><b>TOLL FREE</b></p>		<p><b>CONFIDENTIALITY NOTICE:</b> 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><b>Phone:</b></p> <p><b>BCBSIL: 800.285.9426</b></p> <p><b>BCBSMT: 888.723.7443</b></p> <p><b>BCBSNM: 800.544.1378</b></p> <p><b>BCBSOK: 800.991.5643</b></p> <p><b>BCBSTX: 800.289.1525</b></p>		<p><b>Fax: 877.243.6930</b></p>	