

VOYDEYA

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"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 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 contraindication(s): _____ _____ 3. 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: _____ _____ 4. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., hematologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Will the patient be using the requested agent in combination with Empaveli (pegcetacoplan), Fabhalta (iptacopan), or Piasky (crovalimab-akkz) for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Will the patient be using the requested agent as add-on therapy to Soliris (eculizumab), Bkemb (eculizumab-aeeb), Epysqli (eculizumab-aagh), or Ultomiris (ravulizumab-cwvz)? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). _____ _____ _____	
Please continue to the next page.	

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

For paroxysmal nocturnal hemoglobinuria (PNH) requests:

8. Was the diagnosis 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? Please note, lab tests are required. Yes No
If yes, please submit lab tests.
9. Does the patient have clinically significant extravascular hemolysis (EVH) as indicated by BOTH of the following: 1) hemoglobin less than or equal to 9.5 g/dL, and 2) an absolute reticulocyte count greater than or equal to $120 \times 10^9/L$ with or without transfusion support? Please note, lab tests are required. Yes No
If yes, please submit lab tests.
10. Has the patient been treated on a stable dose of Soliris (eculizumab), Bkemv (eculizumab-aeeb), Epysqli (eculizumab-aagh), or Ultomiris (ravulizumab-cwvz) for at least the previous 6 months? Yes No

For renewal requests:

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

For renewal paroxysmal nocturnal hemoglobinuria (PNH) requests:

12. 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)? Yes No
If yes, please submit medical records.

Please fax or mail this form to:

Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

Phone:

BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

Fax: 877.243.6930

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.