



Voydeya Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date
11-15-2025

Date of Origin
05-16-2024

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Voydeya	danicopan tab ; danicopan tab therapy pack	100 MG ; 50 & 100 MG	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Voydeya	danicopan tab	100 MG	180	Tablets	30	DAYS			
Voydeya	danicopan tab therapy pack	50 & 100 MG	1	Box	30	DAYS			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Voydeya	danicopan tab ; danicopan tab therapy pack	100 MG ; 50 & 100 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Voydeya	danicopan tab	100 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Voydeya	danicopan tab therapy pack	50 & 100 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Initial Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) AND ALL of the following: <ol style="list-style-type: none"> 1. The diagnosis was 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 (lab tests required) AND

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	<p>2. The patient has clinically significant extravascular hemolysis (EVH) as indicated by BOTH of the following:</p> <ul style="list-style-type: none"> A. Hemoglobin less than or equal to 9.5 g/dL (lab test required) AND B. Absolute reticulocyte count greater than or equal to $120 \times 10^9/L$ with or without transfusion support (lab test required) AND <p>3. BOTH of the following:</p> <ul style="list-style-type: none"> A. The patient has been treated on a stable dose of Soliris (eculizumab), Bkembv (eculizumab-aeeb), Epysqli (eculizumab-aagh), or Ultomiris (ravulizumab-cwvz) for at least the previous 6 months AND B. The patient will be using the requested agent as add-on therapy to Soliris (eculizumab), Bkembv (eculizumab-aeeb), Epysqli (eculizumab-aagh), or Ultomiris (ravulizumab-cwvz) OR <p>B. The patient has another FDA labeled indication for the requested agent and route of administration AND</p> <p>2. If the patient has an FDA labeled indication, then ONE of the following:</p> <ul style="list-style-type: none"> A. The patient's age is within FDA labeling for the requested indication for the requested agent OR B. There is support for using the requested agent for the patient's age for the requested indication AND <p>3. The prescriber is a specialist in the area of the patient's diagnosis (e.g., hematologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND</p> <p>4. The patient will NOT be using the requested agent in combination with Empaveli (pegcetacoplan), Fabhalta (iptacopan), or Piaskey (crovalimab-akkz) AND</p> <p>5. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months BCBSIL, BCBSMT, and BCBSTX: 12 months ALL other plans: 3 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when the following are met:</p> <ul style="list-style-type: none"> 1. The member resides in Ohio AND 2. The plan is Fully Insured or HIM Shop (SG) AND BOTH of the following <ul style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. ONE of the following: <ul style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p>

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	<p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p> <p>Renewal Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has been previously approved for the requested agent through the plan’s Prior Authorization process (Note: patients not previously approved for the requested agent will require initial evaluation review) AND 2. ONE of the following: <ol style="list-style-type: none"> A. The patient has a diagnosis of Paroxysmal Nocturnal Hemoglobinuria (PNH) AND 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) (medical records required) OR B. The patient has a diagnosis other than PNH AND has had clinical benefit with the requested agent AND 3. The prescriber is a specialist in the area of the patient’s diagnosis (e.g., hematologist), or the prescriber has consulted with a specialist in the area of the patient’s diagnosis AND 4. The patient will be using the requested agent as add-on therapy to Soliris (eculizumab), Bkembv (eculizumab-aeeb), Epysqli (eculizumab-aagh), or Ultomiris (ravulizumab-cwvz) AND 5. The patient will NOT be using the requested agent in combination with Empaveli (pegcetacoplan), Fabhalta (iptacopan), or Piaskey (crovalimab-akkz) AND 6. The patient does NOT have any FDA labeled contraindications to the requested agent <p>Length of Approval:</p> <p>BCBSOK: 36 months ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity Limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication OR B. BOTH of the following:

Module	Clinical Criteria for Approval
	<ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication AND 2. There is support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit OR <p>c. BOTH of the following:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication <p>Length of Approval:</p> <p>BCBSIL: 12 months ALL other plans: INITIAL: 3 months; RENEWAL 12 months</p>