

**PRIOR AUTHORIZATION REQUEST FORM
PAROXYSMAL NOCTURNAL HEMOGLOBINURIA**

Empaveli®, Epysqli®, Fabhalta®, PiaSky®, Soliris®, Ultomiris®, Voydeya™

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: Individual Exchange: 833-981-0214, Commercial Groups: 833-981-0213, U of U Health Employees: 833-443-3440

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

| | | |
|----------------|--------------|-----------------|
| Date: | Member Name: | ID#: |
| DOB: | Gender: | Physician: |
| Office Phone: | Office Fax: | Office Contact: |
| Height/Weight: | HCPCS Code: | |

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Preferred/Non-Formulary

1. Preferred
 - A. Ultomiris® (ravulizumab)
2. Non-Preferred
 - A. Epysqli® (eculizumab-aagh)
3. Non-Formulary
 - A. Empaveli® (pegcetacoplan), Fabhalta® (iptacopan), PiaSky® (crovalimab-akkz), Soliris® (eculizumab), Voydeya™ (danicipan)

Product being requested: _____

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

| Questions | Yes | No | Comments/Notes |
|--|--------------------------|--------------------------|-------------------------------------|
| 1. Is the requesting provider a hematologist or oncologist, or in consultation with one? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Is the diagnosis of Paroxysmal Nocturnal Hemoglobinuria (PNH) confirmed by flow cytometry? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 3. Is the member transfusion dependent requiring at least four transfusions in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 4. Does the member have a history of a major thrombotic event? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 5. Does the member have high lactate dehydrogenase (LDH) activity with serum levels ≥1.5 times the upper limit of normal and have clinical symptoms? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |

| | | | |
|--|--------------------------|--------------------------|-------------------------------------|
| 6. Does documentation include baseline values of serum lactate dehydrogenase (LDH), hemoglobin level, and frequency of packed red blood cell transfusions? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 7. Has the member had Neisseria meningitis vaccination at least 2 weeks prior to start date? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Is the prescribing physician enrolled in the Risk Evaluation and Mitigation Strategies (REMS) program for the requested agent? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. If the request for Epysqli®, has the member tried and failed Ultomiris®, unless contraindicated? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 10. Will the requested therapy be used in combination with another complement inhibitor to treat PNH? | <input type="checkbox"/> | <input type="checkbox"/> | |

REAUTHORIZATION

| | | | |
|---|--------------------------|--------------------------|-------------------------------------|
| 1. Is the request for reauthorization of therapy? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Has the member had a decrease in serum LDH from baseline? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 3. Has the member had an improvement in hemoglobin level from baseline? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 4. Has the member had a decrease in packed red blood cell transfusion frequency from baseline? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 5. Has the member maintained meningitis vaccination in accordance to current recommendations for treatment? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Is the member receiving a complement inhibitor in combination with another complement inhibitor? | <input type="checkbox"/> | <input type="checkbox"/> | |

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

PRESCRIBER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Physician's Signature:

Date:

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Policy PHARM-M048
 Origination Date: 08/29/2024
 Reviewed/Revised Date: 11/12/2025
 Next Review Date: 11/12/2026
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