Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Empaveli

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this an initial request or re-authorization request?

☐ Initial request ☐ Re-authorization request

Q2. What is the diagnosis?

☐ Paroxysmal Nocturnal Hemoglobinuria (PNH)
☐ Complement 3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN)
☐ Other

Q3. If other, please specify:

Q4. Is the diagnosis confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) which demonstrates at least one of the following?

☐ At least 5 percent PNH type III red cells
☐ Greater than 50 percent of GPI-AP-deficient polymorphonuclear cells (PMNs)

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☐ None of the above

Q5. Is flow cytometry used to demonstrate GPI-AP deficiency?

☐ Yes ☐ No

Q6. Does the patient have clinical manifestations of disease (i.e., lactate dehydrogenase (LDH) level greater than 1.5 times the upper limit of normal, thrombosis, organ dysfunction, transfusion dependence)?

☐ Yes ☐ No

Q7. For the diagnosis Paroxysmal Nocturnal Hemoglobinuria (PNH), does the patient meet all of the following for continuation?

☐ No evidence of unacceptable toxicity or disease progression

☐ Documented positive clinical response such as improvement in hemoglobin levels, normalization of LDH levels

☐ None of the above

Q8. Is the diagnosis confirmed by kidney biopsy?

☐ Yes ☐ No

Q9. Do labs or chart notes show the patient has proteinuria >= 1g/day or baseline urine protein-to-creatinine ratio (UPCR) is >= 1g/g in the past 3 months prior to starting the requested drug?

☐ Yes ☐ No

Q10. Has the patient received stable and optimized doses of angiotensin-converting enzyme inhibitors, angiotensin receptor blockers and/or sodium-glucose cotransporter-2 (SGLT2) inhibitors in the 3 months prior to initiation of requested drug or does the patient have intolerance or contraindication to these drugs?

☐ Yes ☐ No

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Q11. For the diagnosis Complement 3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN), does the patient meet all of the following for continuation?

☐ No evidence of unacceptable toxicity or disease progression
☐ Documentation of benefit from therapy evidenced by decreased levels of proteinuria or UPCR from baseline
☐ None of the above

Q12. A coverage consideration cannot be considered without the submission of medical chart documentation supporting your responses. Have you attached all required documentation?

☐ Yes ☐ No

Q13. Has the provider attached all necessary medical chart documentation?

☐ Yes ☐ No

Prescriber Signature _____ Date _____

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