Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Fabhalta

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. Will the medication be prescribed by or in consultation with a nephrologist for primary immunoglobin A nephropathy (IgAN) and complement 3 glomerulopathy (C3G) ?

☐ Yes ☐ No ☐ NA

Q2. What is the diagnosis?

☐ Paroxysmal Nocturnal Hemoglobinuria (PNH)
☐ Primary Immunoglobulin A Nephropathy (IgAN)
☐ Complement 3 Glomerulopathy (C3G)
☐ Other:

Q3. If other, please specify:

Q4. What is the request for?

☐ Initial therapy for Paroxysmal Nocturnal hemoglobinuria (PNH) - go to Q5.
☐ Initial therapy for primary immunoglobulin A nephropathy (IgAN) - go to Q11.

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☐ Initial therapy for compliment 3 glomerulopathy (C3G) - go to Q15.
☐ Reauthorization therapy for PNH - go to Q9.
☐ Reauthorization Therapy for IgAN - go to Q14.
☐ Reauthorization therapy for C3G - go to Q19.

Q5. Was the diagnosis of PNH confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) (e.g., at least 5% PNH cells, at least 51% of GPI-AP deficient polymorphonuclear cells)?

☐ Yes ☐ No

Q6. Was flow cytometry used to demonstrate GPI-APs deficiency? Results must be included.

☐ Yes ☐ No

Q7. Does the member have and exhibit clinical manifestations of disease (e.g., lactate dehydrogenase [LDH] > 1.5 upper limit of normal [ULN], thrombosis, renal dysfunction, pulmonary hypertension, dysphagia)?

☐ Yes ☐ No

Q8. Will the requested medication be used in combination with another complement inhibitor (e.g., Empaveli, Piasky, Soliris, Ultomiris) for the treatment of PNH?

☐ Yes ☐ No

Q9. Does the member demonstrate a positive response to therapy (e.g., improvement in hemoglobin levels, normalization of lactate dehydrogenase [LDH] levels)?

☐ Yes ☐ No

Q10. Will the requested medication be used in combination with another complement inhibitor (e.g., Empaveli, Piasky, Soliris, Ultomiris) for the treatment of PNH?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q11. Does the member have a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy (with results attached)?

☐ Yes ☐ No

Q12. Does the member have either of the following obtained within 3 months prior to initiation of the requested drug? Lab reports or chart notes with results must be included.

☐ Proteinuria greater than or equal to 0.5 g/day
☐ UPCR greater than or equal to 0.8 g/g
☐ None of the above

Q13. For (IgAN), has the member received a stable dose of maximally tolerated renin-angiotensin system (RAS) inhibitor therapy (e.g., angiotensin converting enzyme inhibitor [ACEI] or angiotensin II receptor blocker [ARB]) for at least 3 months prior to initiation of therapy, or does the member have an intolerance or contraindication to RAS inhibitors?

☐ Yes ☐ No

Q14. For (IgAN), is the member experiencing benefit from therapy as evidenced by either of the following? Lab reports or chart notes must be included.

☐ Decreased levels of proteinuria from baseline
☐ Decrease in UPCR from baseline
☐ None of the above

Q15. Does the member have a diagnosis of complement 3 glomerulopathy (C3G) confirmed by kidney biopsy (with results attached)?

☐ Yes ☐ No

Q16. Does the member have either of the following obtained within 3 months prior to initiation of the requested drug? Lab reports or chart notes must be included.

☐ Proteinuria greater than or equal to 1 g/day
☐ UPCR greater than or equal to 1.0 g/g
☐ None of the above

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Patient Name:	**Prescriber Name:**

Q17. Does the member have reduced serum C3 (defined as less than 0.85 times the lower limit of normal per the reference ranges provided) at baseline? Lab reports are chart notes must be included.

☐ Yes ☐ No

Q18. For (C3G), has the member received a stable dose of maximally tolerated renin-angiotensin system (RAS) inhibitor therapy (e.g., angiotensin converting enzyme inhibitor [ACEI] or angiotensin II receptor blocker [ARB]) for at least 3 months prior to initiation of therapy, or does the member have an intolerance or contraindication to RAS inhibitors?

☐ Yes ☐ No

Q19. For (C3G), is the member experiencing benefit from therapy as evidenced by either of the following? Lab reports or chart notes must be included.

☐ Decreased levels of proteinuria from baseline
☐ Decrease in UPCR from baseline
☐ None of the above

Q20. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

☐ Yes ☐ No

Q21. Additional Information:

Prescriber Signature

Date

v2026