



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Empaveli - Non-PDL

Phone: 866-841-7659

Fax back to: 866-240-3712

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.

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:		Address:	
City, State ZIP:		City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP		Specialty Pharmacy (if applicable):	
Drug Name:		Strength:	
Quantity:		Refills:	
Directions:			
Diagnosis Code:		Diagnosis:	
Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..			

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)

☐ None of the above

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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?**☐ 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 greater than or equal to 1g/day or baseline urine protein-to-creatinine ratio (UPCR) is greater than or equal to 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**Q11. For the diagnosis Complement 3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN), does the patient meet all of the following?**

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☐ 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. Does the patient have a serious systemic infection (such as Streptococcus pneumoniae, Neisseria meningitidis and Haemophilus influenzae type B)? ☐ Yes☐ No	
Q13. Will the patient use concomitantly with another complement inhibitor for the treatment of PNH (transition to Empaveli is allowed)? ☐ Yes☐ No	
Q14. Is there documentation of diagnosis with chart notes attached? ☐ Yes☐ No	
Q15. Is the medication prescribed by or in consultation with a nephrologist? ☐ Yes☐ No	
Q16. A coverage consideration cannot be considered without the submission of medical chart documentation supporting your responses. Have you attached all required documentation? ☐ Yes☐ No	
Q17. Has the provider attached all necessary medical chart documentation? ☐ Yes☐ No	
Q18. Additional Information: 	

Prescriber Signature_____
Date



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