PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 6/13/2025
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Paroxysmal nocturnal hemoglobinuria (PNH) (If checked, go to 2) ☐
   - Primary immunoglobulin A nephropathy (IgAN) (If checked, go to 9) ☐
   - Complement 3 glomerulopathy (C3G) (If checked, go to 17) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Will the patient receive the requested drug in combination with another complement inhibitor (e.g., Empaveli, Piasky, Soliris, Ultomiris) for the treatment of PNH? **Y** ☐ **N** ☐
3. Is the request for continuation of therapy? **Y** ☐ **N** ☐
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
5. Did the patient demonstrate a positive response to therapy (e.g., improvement in hemoglobin levels, normalization of lactate dehydrogenase [LDH] levels)? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
6. 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 poly-morphonuclear cells)? **Y** ☐ **N** ☐
7. Was flow cytometry used to demonstrate GPI-APs deficiency? ACTION REQUIRED: If Yes, attach flow cytometry used to show results of glycosylphosphatidylinositol-anchored proteins (GPI-APs) deficiency. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
8. Does the patient have and exhibit clinical manifestations of disease (e.g., LDH greater than 1.5 ULN, thrombosis, renal dysfunction, pulmonary hypertension, dysphagia)? **Y** ☐ **N** ☐
9. Is the request for continuation of therapy? **Y** ☐ **N** ☐
10. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐

11. Has the patient experienced benefit from therapy as evidenced by decreased levels of proteinuria or urine protein-to-creatinine ratio (UPCR) from baseline? ACTION REQUIRED: If Yes, please attach supporting laboratory report or chart note(s) indicating the patient has decreased levels of proteinuria or UPCR from baseline.
    Note: Submit supporting documentation — **Y** ☐ **N** ☐

12. Has the diagnosis of primary immunoglobulin A nephropathy (IgAN) been confirmed by a kidney biopsy? ACTION REQUIRED: If Yes, please attach supporting chart note(s) or biopsy report confirming diagnosis of primary immunoglobulin A nephropathy (IgAN).
    Note: Submit supporting documentation — **Y** ☐ **N** ☐

13. Does the patient have proteinuria greater than or equal to 1 g/day? ACTION REQUIRED: If Yes, please attach supporting laboratory report or chart note(s) indicating the patient has proteinuria greater than or equal to 1 g/day.
    ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

14. Does the patient have a urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.8 g/g? ACTION REQUIRED: If Yes, please attach supporting laboratory report or chart note(s) indicating the patient has a baseline urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.8 g/g.
    ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

15. Has the patient 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? — **Y** ☐ **N** ☐

16. Does the patient have an intolerance or contraindication to RAS inhibitors? — **Y** ☐ **N** ☐

17. Is the request for continuation of therapy? — **Y** ☐ **N** ☐

18. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? — **Y** ☐ **N** ☐

19. Has the patient experienced benefit from therapy as evidenced by decreased levels of proteinuria or urine protein-to-creatinine ratio (UPCR) from baseline? ACTION REQUIRED: If Yes, please attach supporting laboratory report or chart note(s) indicating the patient has decreased levels of proteinuria or UPCR from baseline. — **Y** ☐ **N** ☐

20. Is the diagnosis of complement 3 glomerulopathy (C3G) confirmed by kidney biopsy? ACTION REQUIRED: If Yes, please attach kidney biopsy confirming a diagnosis of complement 3 glomerulopathy (C3G).
    ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

21. Does the patient have proteinuria greater than or equal to 1 g/day? ACTION REQUIRED: If Yes, please attach supporting laboratory report or chart note(s) indicating the patient has proteinuria greater than or equal to 1 g/day.
    ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

22. Does the patient have a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.0 g/g? ACTION REQUIRED: If Yes, please attach supporting laboratory report or chart note(s) indicating the patient has a baseline urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.0 g/g.
    ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

23. Does the patient have reduced serum C3 (defined as less than 0.85 times the lower limit of normal per the reference ranges provided) at baseline? ACTION REQUIRED: If Yes, please attach laboratory report and/or chart note(s) showing a reduction in serum C3.
    ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

24. Has the patient 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? — **Y** ☐ **N** ☐

25. Does the patient have an intolerance or contraindication to RAS inhibitors? — **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date