



**BlueCross
BlueShield**

**FABHALTA
Federal Employee Program. PRIOR APPROVAL REQUEST**

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn: Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R			Physician Signature:		
PHYSICIAN COMPLETES						

Fabhalta (iptacopan)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its entirety for processing

Is this request for brand or generic? ☐ Brand ☐ Generic

1. Will the patient need more than 400 milligrams per day? ☐ Yes* ☐ No

***If YES**, please specify the requested milligrams per day: _____ mg per day

2. Is the prescriber enrolled in the Fabhalta REMS program? ☐ Yes ☐ No

3. What is the patient's diagnosis?

☐ Paroxysmal nocturnal hemoglobinuria (PNH)

a. Will this medication be used in combination with another Prior Authorization (PA) medication for PNH? ☐ Yes* ☐ No

***If YES**, please specify medication: _____

b. Has the patient been on this medication continuously for the last **6 months** excluding samples? **Please select answer below:**

☐ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have a documented baseline value for hemoglobin (Hgb)? ☐ Yes ☐ No

ii. Has or will the patient be vaccinated against encapsulated bacteria, including *Streptococcus pneumoniae*, *Neisseria meningitidis*, and *Haemophilus influenzae* type B at least 2 weeks prior to initiating therapy? ☐ Yes ☐ No*

***If NO**, is urgent Fabhalta therapy indicated for this patient (e.g., the risks of delaying treatment with Fabhalta outweigh the risk of developing an encapsulated bacterial infection)? ☐ Yes ☐ No

☐ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has the patient's hemoglobin (Hgb) increased from pretreatment baseline? ☐ Yes ☐ No

ii. Has the patient experienced unacceptable toxicity while on the requested therapy? ☐ Yes ☐ No

☐ Primary immunoglobulin A nephropathy (IgAN)

a. Will this medication be used in combination with the maximum recommended or maximum tolerated dose of ACEI or ARB therapy? ☐ Yes ☐ No

b. Has the patient been on this medication continuously for the last **6 months** excluding samples? **Please select answer below:**

☐ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Has or will the patient be vaccinated against encapsulated bacteria, including *Streptococcus pneumoniae*, *Neisseria meningitidis*, and *Haemophilus influenzae* type B at least 2 weeks prior to initiating therapy? ☐ Yes ☐ No*

***If NO**, is urgent Fabhalta therapy indicated for this patient (e.g., the risks of delaying treatment with Fabhalta outweigh the risk of developing an encapsulated bacterial infection)? ☐ Yes ☐ No

ii. Has the diagnosis been confirmed by a kidney biopsy? ☐ Yes ☐ No

iii. Is the patient at risk of rapid disease progression as indicated by a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 grams per gram? ☐ Yes ☐ No

iv. Does the patient have an eGFR greater than or equal to 20 milliliters per minute per 1.73 square meter (mL/min/1.73m²)? ☐ Yes ☐ No

v. Is this medication being prescribed by or recommended by a nephrologist? ☐ Yes ☐ No

☐ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has there been a decrease in the patient's urine protein-to-creatinine ratio (UPCR)? ☐ Yes ☐ No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Fabhalta – FEP MD Fax Form Revised 5/23/2025



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PAGE 2 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

☐ Complement 3 glomerulopathy (C3G)

a. Will this medication be used in combination with the maximum recommended or maximum tolerated dose of ACEI or ARB therapy? ☐ Yes ☐ No

b. Has the patient been on this medication continuously for the last **6 months** excluding samples? *Please select answer below:*

☐ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Has or will the patient be vaccinated against encapsulated bacteria, including *Streptococcus pneumoniae*, *Neisseria meningitidis*, and *Haemophilus influenzae* type B at least 2 weeks prior to initiating therapy? ☐ Yes ☐ No*

**If NO*, is urgent Fabhalta therapy indicated for this patient (e.g., the risks of delaying treatment with Fabhalta outweigh the risk of developing an encapsulated bacterial infection)? ☐ Yes ☐ No

ii. Will this medication be used to reduce proteinuria? ☐ Yes ☐ No

iii. Has the diagnosis been confirmed by a kidney biopsy? ☐ Yes ☐ No

iv. Does the patient have a documented baseline urine protein-to-creatinine ratio (UPCR)? ☐ Yes ☐ No

☐ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has there been a decrease in the patient's urine protein-to-creatinine ratio (UPCR)? ☐ Yes ☐ No

☐ Other (please specify): _____

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