BlueCross BlueShield Federal Employee Program

# FABHALTA
# 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: ❑Male ❑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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## 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):*** _____