Voydeya (danicopan)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Paroxysmal nocturnal hemoglobinuria (PNH) ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Initial Request:

Does the patient have a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)? □ **Yes** □ **No**

Was the patient's diagnosis confirmed by peripheral blood flow cytometry diagnostic testing showing the absence or deficiency of glycosylphosphatidylinositol-anchored proteins? □ **Yes** □ **No** ***Please provide documentation***

Is the requested agent being prescribed by, or in consultation with a hematologist or oncologist? □ **Yes** □ **No**

Does the patient have a hemoglobin of ≤ 9.5 g/dl? □ **Yes** □ **No** ***Please provide documentation***

Does the patient have a platelet count of ≥ 30,000 microliters? □ **Yes** □ **No** ***Please provide documentation***

Has the patient been on a stable regimen of an anti-C5 (Soliris(eculizumab) or Ultomiris(ravulizumab)) antibody treatment? □ **Yes** □ **No** ***Please provide documentation***

Will the patient continue on the anti-C5 (Soliris(eculizumab) or Ultomiris(ravulizumab)) antibody treatment? □ **Yes** □ **No**

Does the patient have have a known aplastic anemia or other bone marrow failure that requires HSCT or other therapies including anti-thymocyte globulin and/or immunosuppressants? □ **Yes** □ **No** ***Please provide documentation***

Does the patient have a known or suspected complement deficiency? □ **Yes** □ **No** ***Please provide documentation***

Will patient use in combination with Fabhalta(iptacopan) or Empaveli(pegcetacoplan)? □ **Yes** □ **No**

Renewal Request:

Is the requested agent being prescribed by, or in consultation with a hematologist or oncologist? □ **Yes** □ **No**

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Has the patient had positive clinical response to therapy? □ **Yes** □ **No** ***Please submit documentation***

Will Voydeya (danicopan) be used in combination with Soliris(eculizumab) or Ultomiris(ravulizumab)? □ **Yes** □ **No**

Will patient use in combination with Fabhalta(iptacopan) or Empaveli(pegcetacoplan)? □ **Yes** □ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909