Empaveli

Prior Authorization Form

Fax completed form to:
855-207-0250
For questions regarding this prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that members receiving a prescription for Empaveli (pegcetacoplan) to meet specific clinical criteria for coverage. Criteria for coverage for Empaveli can be found the following location:

- The Preferred Drug List (PDL) available at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER REPRESENTATIVE

Member Name	Member Date of Birth	Member Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating prescriber)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request:** ☐ PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH) ☐ OTHER:_____

Qualifications for coverage:

Does the member have transfusion dependent anemia?	☐ YES ☐ NO
Does the member have symptoms of thromboembolic complications (abdominal pain, shortness of breath, chest pain, end-organ damage, fatigue)?	☐ YES ☐ NO
Has the member received one of the following? • A full course of meningococcal, pneumococcal, and Hib vaccines at least 2 weeks prior to starting treatment • A test for antibodies against encapsulated bacteria at least 2 weeks prior to starting treatment • Prophylactic antibiotics against encapsulated bacteria prior to starting treatment	☐ YES ☐ NO

Please confirm that all the following is attached to the request, along with any other relevant documentation:

☐ Documentation of lab results confirming a diagnosis of PNH
☐ (Renewal ONLY): Documentation supporting that the member has experienced and/or maintained a clinical benefit since starting treatment with Empaveli, as evidenced by medical documentation (e.g. reduced fatigue, decrease in transfusions, increase in Hb levels, or normalization of LDH).

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the member.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #