US Family Health Plan
Prior Authorization Request Form for
Iptacopan HCL (Fabhalta)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Initial approval expires after 6 months, renewal approves for lifetime.
For renewal of therapy, an initial USFHP prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #:		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? ***Please choose "No" if the patient did not previously have a TRICARE approved PA for Fabhalta.***	☐ Yes Proceed to question **2**	☐ No Proceed to question **3**
2. Has documentation been submitted to confirm positive clinical response including increase in or stabilization of hemoglobin levels, decreased transfusion requirements or transfusion independence, or reductions in hemolysis? NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed by a hematologist or oncologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

	5. Does the patient have a documented diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
	6. Is the provider aware of all monitoring requirements, screening precautions, importance of medication adherence, and REMS requirements?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
	7. Is the patient receiving C3 or C5 inhibitors with Fabhalta, including but not limited to the following: eculizumab (Soliris), ravulizumab (Ultomiris), danicopan (Voydeya), or pegcetacoplan (Empaveli)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____