US Family Health Plan

Prior Authorization Request Form for

# Danicopan (Voydeya)

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**

Prior authorization for initial therapy expires in 6 months. Prior authorization for continuation of therapy does not expire.

**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 the requested medication.* | ☐ Yes<br>Proceed to question **9** | ☐ No<br>Proceed to question **2** |
| **2. Is the patient 18 years of age or older?** | ☐ Yes<br>Proceed to question **3** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3. Is the requested medication prescribed by a hematologist or oncologist?** | ☐ Yes<br>Proceed to question **4** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. Does the patient have documented diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **5. Has the patient tried and failed monotherapy with a C5 inhibitor for six months (for example, eculizumab (Soliris), ravulizumab (Ultomiris), etc.), and has residual anemia?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **6. Is the patient receiving a C5 inhibitor therapy (for example, eculizumab (Soliris), ravulizumab (Ultomiris), etc.) concurrently with the requested medication?** | ☐ Yes<br>Proceed to question **7** | ☐ No<br>**STOP**<br>**Coverage not approved** |

| | | |
|---|---|---|
| **7. Is the provider aware of all monitoring requirements, screening precautions, importance of medication adherence, and REMS requirements?** | ☐ Yes<br>Proceed to question **8** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **8. Is the patient receiving C3 or Complement Factor B inhibitors with the requested medication, including but not limited to the following: iptacopan (Fabhalta), or pegcetacoplan (Empaveli)?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**Sign and date below** |
| **9. Does the patient have documentation of positive clinical response including increase in or stabilization of hemoglobin levels, decreased transfusion requirements or transfusion independence, reductions in hemolysis?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

**Step 3** **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date