# PRIOR AUTHORIZATION REQUEST

## VOYXACT

**Patient Information:**

| | |
|---|---|
| Name: | |
| Member ID: | |
| Address: | |
| City, State, Zip: | |
| Date of Birth: | |

**Prescriber Information:**

| | |
|---|---|
| Name: | |
| NPI: | |
| Phone Number: | |
| Fax Number | |
| Address: | |
| City, State, Zip: | |

**Requested Medication**

| | |
|---|---|
| Rx Name: | |
| Rx Strength | |
| Rx Quantity: | |
| Rx Frequency: | |
| Rx Route of Administration: | |
| Diagnosis and ICD Code: | |

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this request for initial therapy or for continuation of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

**If you have any questions, call: 1-888-258-8250**

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| 3 | Has the patient been receiving medication samples of the requested medication?<br>[If yes, skip to question 7.] | Yes | No |
| 4 | Does the patient have a previously approved prior authorization (PA) on file with the current plan?<br>[Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]<br>[If no, skip to question 7.] | Yes | No |
| 5 | Has the patient been established on therapy for at least 3 months?<br>[If no, skip to question 7.] | Yes | No |
| 6 | Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation.<br>[No further questions.] | Yes | No |
| 7 | What is the indication or diagnosis?<br>[] Immunoglobulin A Nephropathy (IgAN) (If checked, go to 8)<br><br>[] Other (If checked, no further questions) | | |
| 8 | Is the patient greater than or equal to 18 years of age?<br>[If no, no further questions.] | Yes | No |
| 9 | Has documentation been submitted to confirm a diagnosis of proteinuria with primary immunoglobulin A nephropathy confirmed by biopsy? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 10 | Has documentation been submitted to confirm that the patient is at risk for rapid disease progression and has a documented lab of urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.75 g/g (within 60 days for request)? ACTION REQUIRED: Submit supporting documentation.<br>[If yes, skip to question 12.] | Yes | No |
| 11 | Has documentation been submitted to confirm that the patient is at risk for rapid disease progression and has a documented lab with proteinuria greater than or equal to 1.0 g/day (within 60 days for request)?<br>[If no, no further questions.] | Yes | No |
| 12 | Has documentation been submitted to show that the patient's estimated glomerular filtration rate (eGFR) is greater than or equal to 30mL/min/1.73m^2?<br>[If no, no further questions.] | Yes | No |
| 13 | Has the patient received any live vaccines within 30 days prior to initiating Voyxact or will the patient be receiving any live vaccines during treatment? | Yes | No |

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|---|---|---|---|
| | [If yes, no further questions.] | | |
| 14 | Does the provider attest that the patient will be evaluated before and during treatment for any signs and symptoms of infections?<br>[If no, no further questions.] | Yes | No |
| 15 | Will the requested medication be used concurrently with a maximally tolerated angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB)?<br>[If yes, skip to question 17.] | Yes | No |
| 16 | Has documentation been submitted to show that there has been a trial and failure (for at least 3 months to maximum tolerated dose), intolerance, or contraindication to an angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB)? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 17 | Will the requested medication be used concurrently with a maximally tolerated sodium-glucose co-transporter 2 (SGLT2) inhibitor?<br>[If yes, skip to question 19.] | Yes | No |
| 18 | Has documentation been submitted to show that there has been a trial and failure (for at least 3 months to maximum tolerated dose), intolerance, or contraindication to a sodium-glucose co-transporter 2 (SGLT2) inhibitor? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 19 | Has documentation been submitted to show that there has been a trial and failure (for at least 2 months with each glucocorticoid), intolerance, or contraindication to TWO glucocorticoids? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 20 | Has documentation been submitted to show that there has been a trial and failure (for at least 3 months), intolerance, or contraindication to Fabhalta (iptacopan)?<br>[If no, no further questions.] | Yes | No |
| 21 | Will the requested medication be used concurrently with another medication to treat immunoglobulin A nephropathy (IgAN)?<br>[Note: Examples are Fabhalta, Filspari, Vanrafia.]<br>[If yes, no further questions.] | Yes | No |
| 22 | Is the requested medication prescribed by or in consultation with a nephrologist?<br>[If no, no further questions.] | Yes | No |
| 23 | Does the dose of the requested medication exceed the Food and Drug Administration (FDA) approved label dosing for the indication?<br>[Note: Dosing is 400 mg subcutaneously once every 4 weeks.] | Yes | No |

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***Please document the diagnoses, symptoms, and/or any other information important to this review:***

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

## FAX COMPLETED FORM TO: 1-833-896-0656

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

**Confidentiality:** The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

**If you have any questions, call: 1-888-258-8250**