PRIOR AUTHORIZATION REQUEST

Veopoz

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.

1	Is the patient currently receiving the requested medication? [If no, skip to question 6.]	Yes	No
2	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 6.]	Yes	No
3	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [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	Yes	No

PRIOR AUTHORIZATION REQUEST

	under initial therapy.] [If no, skip to question 6.]		
4	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [NOTE: Examples of a response to therapy include increased serum albumin levels, maintenance of serum albumin levels within a normal range, a reduction in albumin transfusions, increases in or maintenance of protein and/or immunoglobulin levels, improvement in clinical outcomes after receipt of therapy (e.g., decreases in the frequency of problematic abdominal pain, bowel movement frequency, facial edema severity, and peripheral edema severity), reduced frequency in hospitalizations, increase in growth percentiles (e.g., body weight-for age and/or stature-for-age percentiles), and/or reduced use of corticosteroids.] [If no, no further questions.]	Yes	No
5	Is the medication prescribed by or in consultation with an immunologist or physician with expertise in managing complement hyperactivation, angiopathic thrombosis, protein losing enteropathy (CHAPLE) disease? [No further questions.]	Yes	No
6	What is the indication or diagnosis? [] CD55-Deficient Protein-Losing Enteropathy (If checked, go to 7) [] All other indications or diagnoses (If checked, no further questions)		
7	Is the patient greater than or equal to 1 years of age? [If no, no further questions.]	Yes	No
8	Has the patient had genetic testing to confirm the diagnosis of complement hyperactivation, angiopathic thrombosis, protein losing enteropathy (CHAPLE) disease with a biallelic CD55 loss of function mutation? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Does the patient have active disease and experiencing one more signs or symptoms within the last 6 months? [NOTE: Examples: abdominal pain, diarrhea, vomiting, peripheral edema, or facial edema.] [If no, no further questions.]	Yes	No
10	Does the patient have a baseline serum albumin level less than or equal to 3.2 g/dL? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Does patient have an active meningococcal infection? [If yes, no further questions.]	Yes	No

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PRIOR AUTHORIZATION REQUEST

12	Will the patient complete or update meningococcal vaccination at least 2 weeks prior to administration of the first dose of Veopoz, unless the risks of delaying Veopoz outweigh the risk of meningococcal infection? [If no, no further questions.]	Yes	No
13	Will the patient complete or update vaccinations for the prevention of Streptococcus pneumonia and Haemophilus influenza type b infections? [If no, no further questions.]	Yes	No
14	Will the patient be treated with other complement inhibitors such as Soliris (eculizumab) or Ultomiris (ravulizumab)? [If yes, no further questions.]	Yes	No
15	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [If yes, no further questions.]	Yes	No
16	Is the medication prescribed by or in consultation with an immunologist or physician with expertise in managing complement hyperactivation, angiopathic thrombosis, protein losing enteropathy (CHAPLE) disease?	Yes	No

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