pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

COMPLEMENT INHIBITORS PRIOR AUTHORIZATION FORM *(form effective 07/01/2022)*

Prior authorization guidelines for **Complement Inhibitors** and **Quantity Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested – LOADING dose:	Drug requested – MAINTENANCE dose:
☐Enjaymo** – Strength & package size: _____ # of vials per dose: _____ # of doses/refills requested: _____ ☐Soliris** – Strength & package size: _____ # of vials per dose: _____ # of doses/refills requested: _____ ☐Ultomiris** – Strength & package size: _____ # of vials per dose: _____ # of doses/refills requested: _____ ☐other: _____ _____ _____ **Indicates drug is included in the Specialty Pharmacy Drug Program. Further information included below.	☐Empaveli – Strength & package size: _____ # of vials per dose: _____ # of doses/refills requested: _____ ☐Enjaymo** – Strength & package size: _____ # of vials per dose: _____ # of doses/refills requested: _____ ☐Soliris** – Strength & package size: _____ # of vials per dose: _____ # of doses/refills requested: _____ ☐Tavneos capsule – Strength: _____ Quantity: _____ Refills requested: _____ ☐Ultomiris** – Strength & package size: _____ # of vials per dose: _____ Refills requested: _____ ☐other: _____
LOADING dose/directions:	MAINTENANCE dose/directions:

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Diagnosis (*submit documentation*):	Dx code (*required*):	Weight (kg):

**SPECIALTY PHARMACY DRUG PROGRAM: Enjaymo, Soliris, and Ultomiris are included in the DHS Specialty Pharmacy Drug Program and is available from DHS's specialty pharmacy. Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Specialty-Pharmacy-Program.aspx for more information about the Specialty Pharmacy Drug Program.	DHS specialty pharmacy: Chartwell Pennsylvania, LP Oakdale, PA Phone: 833-710-0211 Fax: 412-920-1869 www.chartwellpa.com
Is the requested medication being prescribed by or in consultation with a specialist (e.g., hematologist/oncologist, neurologist, nephrologist, etc.)?	☐Yes ☐No *Submit documentation of consultation if applicable.*

INITIAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐The beneficiary is up to date on the following vaccines as recommended in the FDA-approved package labeling:
- ☐meningococcal conjugate (MenACWY; Menactra, Menveo)
- ☐meningococcal serogroup B (MenB; Bexsero, Trumenba)
- ☐pneumococcal conjugate (PCV13; Prevnar 13)
- ☐pneumococcal polysaccharide (PPSV23; Pneumovax 23)
- ☐Haemophilus influenza (Hib)

☐For the treatment of generalized myasthenia gravis:
- ☐Has a positive serologic test for anti-AChR antibodies
- ☐Has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy
- ☐Has a myasthenia gravis-specific activities of daily living scale (MG-ADL) total score ≥ 6 at initiation of therapy
- ☐Failed treatment over 6 months or more with 2 or more immunosuppressive therapies either in combination or as monotherapy
- ☐Has a contraindication or intolerance to immunosuppressive therapies
- ☐Failed treatment with IVIG
- ☐Has a contraindication or intolerance to IVIG
- ☐Failed treatment with plasma exchange
- ☐Has a contraindication or intolerance to plasma exchange

☐For the treatment of neuromyelitis optica spectrum disorder:
- ☐Failed treatment with rituximab
- ☐Has a contraindication or intolerance to rituximab

☐For Empaveli (pegcetacoplan):
- ☐Has results of a recent lactate dehydrogenase level
- ☐Prescribed dose is appropriate based on recent lactate dehydrogenase level

☐For Tavneos (avacopan):
- ☐Prescribed dose is appropriate based on concomitant strong CYP3A4 inhibitors (e.g., protease inhibitors, azole antifungals, nefazodone)
- ☐Not taking concomitant strong CYP3A4 inhibitors *(submit complete medication list)*

RENEWAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Tolerated the requested medication (no significant adverse effects)
☐Experienced a positive clinical response to the requested medication

☐For Empaveli (pegcetacoplan):
- ☐Has results of a recent lactate dehydrogenase level
- ☐Prescribed dose is appropriate based on recent lactate dehydrogenase level

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☐ For Tavneos (avacopan):
- ☐ Prescribed dose is appropriate based on concomitant strong CYP3A4 inhibitors (e.g., protease inhibitors, azole antifungals, nefazodone)
- ☐ Not taking concomitant strong CYP3A4 inhibitors *(submit complete medication list)*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: