Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
GIVLAARI (Givosiran Sodium) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **GIVLAARI (Givosiran Sodium).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a hematologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____
2. Indicate the Member's diagnosis for the requested medication: _____
3. Member ≥18 years of age? AND
   □ No □ Yes
4. Does the member have clinical symptoms consistent with active acute hepatic porphyria [AHP] (e.g., neurovisceral attacks, abdominal pain, central nervous system symptoms such as paralysis or psychosis)? **AND**
   □ No □ Yes
5. Has documentation of ≥2 porphyria attacks within the last 6 months leading to hospitalization, emergency department visits, or intravenous hemin administration? **AND**
   □ No □ Yes
6. Was an elevated urinary (24-hour urine collection) porphobilinogen (PBG) or aminolevulinic acid (ALA) preformed within the past year?
   □ No □ Yes
7. Does the member have any of the following?
   a. Active HIV, hepatitis C virus, or hepatitis B infection(s)
   b. Planned liver transplantation
   c. History of recurrent pancreatitis

   □ No □ Yes

For Continuation of Therapy, Please Respond to Additional Questions Below:

1. Reassess every 6 months to determine need for continued therapy. Therapy should be discontinued if patient meets any one of the following criteria:
   a. No improvement in number of attacks leading to hospitalizations, emergency department visits, clinic visits or hemin requirements after 6 months of treatment (i.e., status stable or worse from baseline)
   b. Clinically significant changes in LFTs, SCr, or eGFR
   c. Nonadherence to the medication

   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility