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:**