SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: PiaSky® (crovalimab-akkz) **SQ (Pharmacy)**
Paroxysmal Nocturnal Hemoglobinuria (PNH)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosing: Piasky® 340 mg/2 mL solution in single-dose vials for infusion

- **Weight ≥ 40 kg to <100kg:**
  - **Loading Dose:** 1,000 mg IV on day 1 followed by 340 mg SQ on days 2, 8, 15, 22
  - **Maintenance Dose:** 680 mg SQ on day 29 and every 4 weeks thereafter
- **Weight ≥ 100 kg:**
  - **Loading Dose:** 1,500 mg IV on day 1 followed by 340 mg SQ on days 2, 8, 15, 22
  - **Maintenance Dose:** 1020 mg SQ on day 29 and every 4 weeks thereafter

Quantity Limit: 6 mL (3 vials) per 28 days

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ❑ Member has a diagnosis of Paroxysmal Nocturnal Hemoglobinuria (PNH) as confirmed by flow cytometry with at least 2 independent flow cytometry reagents on at least 2 cell lineages (e.g., RBCs and WBCs) demonstrating that the patient's peripheral blood cells are deficient in glycosylphosphatidylinositol (GPI)-linked proteins (must submit labs)
- ❑ Member is 13 years of age or older
- ❑ Member body weight is at least 40 kg
- ❑ Must be prescribed by, or in consultation with, a hematologist or other specialist in paroxysmal nocturnal hemoglobinuria
- ❑ Member will **NOT** use requested agent in combination with Soliris (eculizumab), Bkemv (eculizumab-aeeb), Epysqli (eculizumab-aagh), Ultomiris (ravulizumab-cwvz), Fabhalta (iptacopan), or Empaveli (pegcetacoplan)
- ❑ Member must not have unresolved serious *Neisseria meningitidis* infection

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet all the relevant criteria identified in the initial criteria
- ❑ Member has an absence of unacceptable toxicity from the drug (e.g., serious meningococcal infections (septicemia and/or meningitis), infusion reactions, serious infections)
- ❑ Member is being continuously monitored for a beneficial response to therapy

Medication being provided by Specialty Pharmacy - PropriumRx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 3/27/2025
REVISED/UPDATED/REFORMATTED: ~~4/15/2025;~~ **6/11/2026**