

Prior Authorization Request Form for
pegcetacoplan injection (Empaveli)



7231 Parkway Drive, Suite 100
Hanover, MD 21076

**Fax completed form and
applicable progress notes to:
(410) 424-4037**

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

For PNH, PA does not expire; for C3G or IC-MPGN, PA expires in 9 months. Initial TRICARE PA approval is required for renewal for C3G and IC-MPGN. Coverage will be approved indefinitely for continuation of therapy.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Provider is aware of all monitoring requirements, screening precautions, importance of medication adherence, and REMS requirements.	☐ Acknowledged Proceed to question 2	
2. Is the patient receiving C3 or C5 inhibitors with Empaveli, including but not limited to the following: eculizumab (Soliris), ravulizumab (Ultomiris), danicopan (Voydeya), or iptacopan (Fabhalta)?	☐ Yes STOP Coverage not approved	☐ No Proceed to question 3
3. Has the patient been vaccinated against certain encapsulated bacteria (for example, Streptococcus pneumoniae, Neisseria meningitidis types A, C, W, Y, and B, and Haemophilus influenzae type B)?	☐ Yes Proceed to question 4	☐ No STOP Coverage not approved
4. What is the diagnosis or indication?	☐ Paroxysmal Nocturnal Hemoglobinuria (PNH) – Proceed to question 5 ☐ Complement 3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN) – Proceed to question 8 ☐ Other diagnosis – STOP – Coverage not approved	
5. Is the patient 18 years of age or older?	☐ Yes Proceed to question 6	☐ No STOP Coverage not approved
6. Does the patient have a documented diagnosis of Paroxysmal Nocturnal Hemoglobinuria (PNH)?	☐ Yes Proceed to question 7	☐ No STOP Coverage not approved

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7. Has the patient been counseled on the appropriate administration of the drug via infusion pump?	☐ Yes Sign and date below	☐ No STOP Coverage not approved
8. Has the patient received this medication under the TRICARE benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.</i>	☐ Yes (subject to verification) Proceed to question 15	☐ No Proceed to question 9
9. Is the patient 12 years of age or older?	☐ Yes Proceed to question 10	☐ No STOP Coverage not approved
10. Is the requested medication being prescribed by a nephrologist?	☐ Yes Proceed to question 11	☐ No STOP Coverage not approved
11. Does the patient have a diagnosis of C3G or IC-MPGN confirmed by biopsy?	☐ Yes Proceed to question 12	☐ No STOP Coverage not approved
12. Does the patient have a urine protein-to-creatinine ratio (UPCR) GREATER THAN OR EQUAL TO 1.0 g/gr?	☐ Yes Proceed to question 13	☐ No STOP Coverage not approved
13. Does the patient have an estimated glomerular filtration rate (eGFR) GREATER THAN OR EQUAL TO 30 mL/min/1.73 m ² ?	☐ Yes Proceed to question 14	☐ No STOP Coverage not approved
14. Is the patient on maximally tolerated renin angiotensin system (RAS) inhibitor (ACE/ARB)?	☐ Yes Sign and date below	☐ No STOP Coverage not approved
15. Has the patient had a response to Empaveli defined by: (a) Reduction in urine protein-to-creatinine ratio (UPCR) from baseline, OR (b) Reduction in proteinuria from baseline, OR (c) Patient's eGFR rate GREATER THAN OR EQUAL TO 30 mL/min/1.73 m ² ?	☐ Yes Sign and date below	☐ No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date

[18 February 2026]

For Internal Use Only

☐ Approved:	Duration of Approval: ____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: