TRICARE Prior Authorization Request Form for
danicopan **(Voydeya)**

JOHNS HOPKINS
HEALTH PLANS
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.

Prior authorization for initial therapy expires in 6 months. Prior authorization for continuation of therapy does not expire.

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. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes Proceed to question **9**	☐ No Proceed to question **2**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication prescribed by a hematologist or oncologist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have documented diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and failed monotherapy with a C5 inhibitor for six months (for example, eculizumab (Soliris), ravulizumab (Ultomiris), etc.), and has residual anemia?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient receiving a C5 inhibitor therapy (for example, eculizumab (Soliris), ravulizumab (Ultomiris), etc.) concurrently with the requested medication?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Is the provider aware of all monitoring requirements, screening precautions, importance of medication adherence, and REMS requirements?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient receiving C3 or Complement Factor B inhibitors with the requested medication, including but not limited to the following: iptacopan (Fabhalta), or pegcetacoplan (Empaveli)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
9. Does the patient have documentation of positive clinical response including increase in or stabilization of hemoglobin levels, decreased transfusion requirements or transfusion independence, reductions in hemolysis?	☐ 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

[13 November 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: