Pyrukynd (mitapivat)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

Revision Date: 08/01/2022

Magellan Rx MANAGEMENT

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Hemolytic anemia with pyruvate kinase deficiency ☐ Other diagnosis: _____ICD-10:_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Is the drug going to be used in conjunction with a clinical trial? ☐ Yes ☐ No
<u>Initial Request</u>:
Does patient have a documented presence of at least 2 variant alleles in the *PKLR* gene, of which at least 1 is a missense variant? ☐ Yes ☐ No *Please provide documentation*.

Is patient homozygous for the c.1436G>A (p.R479H) variant? ☐ Yes ☐ No *Please provide documentation*.

Does patient have 2 non-missense variants (without the presence of another missense variant) in the *PKLR* gene? ☐ Yes ☐ No *Please provide documentation*.

Does patient have a baseline serum hemoglobin level < 10 g/dL? ☐ Yes ☐ No *Please provide documentation*.

Does patient require more than 6 transfusions in the prior year? ☐ Yes ☐ No *Please provide documentation*.

Have other causes of hemolytic anemia have been ruled out (e.g., immune hemolysis, other enzyme deficiencies, vitamin/mineral deficiencies)? ☐ Yes ☐ No *Please provide documentation*.

<u>Renewal Request</u>:
Has patient shown a beneficial response to therapy compared to pre-treatment baseline in 1 or more of the following? ☐ Yes ☐ No *Please provide documentation*.
☐ Hemoglobin (Hb) response (defined as a ≥ 1.5 g/dL increase in hemoglobin level without transfusion over a 4-week or longer time period) ☐ Yes ☐ No *Please provide documentation*.
☐ Transfusion reduction response (defined as a ≥ 33% reduction in the number of red blood cell [RBC] units transfused compared to historical transfusion burden) ? ☐ Yes ☐ No *Please provide documentation*.
☐ Patient had an increase in Hb and/or decrease in transfusion requirement, to a lesser extent than the above? ☐ Yes ☐ No *Please provide documentation*.

Has patient had an improvement in the signs and symptoms (e.g., fatigue, jaundice, shortness of breath) and/or markers of hemolysis (e.g., indirect bilirubin, reticulocyte count, LDH, haptoglobin)? ☐ Yes ☐ No *Please provide documentation*.

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Does patient have evidence of decreased hemolysis as evident by a change <u>in each of the following lab values</u> from baseline? □ Yes □ No *Please provide documentation*.

- **Decrease in Serum Bilirubin**
- **Decrease in Serum LDH**
- **Increase in Serum Haptoglobin**
- **Decrease in Reticulocyte count**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

***Please note:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Revision Date: 08/01/2022