



Federal Employee Program.

(givosiran) GIVLAARI
PRIOR APPROVAL REQUEST

Send completed form to:
FAX: 855-895-3504
FOR URGENT FAX: 844-244-0226

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Form with Patient Information and Provider Information sections. Includes fields for Date, Patient Name, Date of Birth, Sex, Street Address, City, State, Zip, Patient ID, Provider Name, Specialty, NPI, Office Phone, Office Fax, Office Street Address, City, State, Zip, and Physician Signature. A large 'R' is present in the Patient ID field.

PHYSICIAN COMPLETES

Givlaari (givosiran)

**Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

NOTE: Form must be completed in its entirety for processing

Is this request for brand or generic? [] Brand [] Generic

1. What is the patient's diagnosis?

[] Acute Hepatic Porphyria (AHP)

[] Other diagnosis (please specify): _____

2. Will a healthcare professional be available to administer Givlaari and give medical support if necessary for anaphylactic reactions? [] Yes [] No

3. Does the prescriber agree to monitor the patient's liver function tests (LFTs)? [] Yes [] No

4. Does the prescriber agree to monitor the patient's renal function? [] Yes [] No

5. Has the patient been on Givlaari continuously for the last 4 months, excluding samples? Please select answer below:

[] NO - this is INITIATION of therapy, please answer the following questions:

a. Has the patient's diagnosis been confirmed by an elevated porphobilinogen (PBG) or delta-aminolevulinic acid (ALA) concentration? [] Yes [] No

b. Has the patient had genetic confirmation of the following: hydroxymethylbilane synthase (HMBS), coproporphyrinogen oxidase (CPOX), protoporphyrinogen oxidase (PPOX), or ALA dehydratase (ALAD) to confirm their diagnosis? [] Yes [] No

c. Does the patient have active, symptomatic disease with at least two documented porphyria attacks requiring acute care in the last six months? [] Yes [] No*

*If NO, is the patient currently receiving prophylactic hemin treatment due to a history of severe or frequent porphyria attacks? [] Yes [] No

d. Have baseline urinary or plasma porphobilinogen (PBG) or delta-aminolevulinic acid (ALA) concentrations been obtained? [] Yes [] No

e. Will the patient be concurrently receiving prophylactic hemin treatment? [] Yes [] No

[] YES - this is a PA renewal for CONTINUATION of therapy, please answer the following questions:

a. Has the patient had a clinical response to therapy as demonstrated by a reduction in the rate of porphyria attacks? [] Yes [] No*

*If NO, has the patient had a clinical response to therapy as demonstrated by a reduction in hemin requirements for acute attacks? [] Yes [] No

b. Have porphobilinogen (PBG) or delta-aminolevulinic acid (ALA) concentration increased from baseline? [] Yes [] No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Givlaari - FEP MD Fax Form Revised 10/21/2022