Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Revcovi™ Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Adenosine deaminase severe combined immune deficiency (ADA-SCID)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Will Revcovi be used in combination with Adagen (pegademase-bovine)? ❑ **Yes** ❑ **No**

Select if the patient has severe combined immunodeficiency disease (SCID) with a definitive diagnosis of adenosine deaminase deficiency (ADA) as determined by the following:

- ❑ Deficient ADA catalytic activity (< 1% of normal) in hemolysates (in untransfused individuals) or in extracts of other cells (e.g., blood mononuclear cells, fibroblasts)
- ❑ Detection of pathogenic mutations in the ADA gene by molecular genetic testing

Does the patient have a marked elevation of the metabolite deoxyadenosine triphosphate (dATP) or total dAdo nucleotides (the sum of deoxyadenosine monophosphate [dAMP], deoxyadenosine diphosphate [dADP] and dATP) in erythrocytes? ❑ **Yes** ❑ **No**

Is the patient **NOT** a candidate for or has failed hematopoietic cell transplantation (HCT)? ❑ **Yes** ❑ **No**

Does the patient have severe thrombocytopenia (< 50,000/mcL)? ❑ **Yes** ❑ **No**

Select if baseline laboratory values documenting the following will be submitted:

- ❑ Plasma ADA activity
- ❑ Red blood cell dATP
- ❑ Trough dAXP levels
- ❑ Total lymphocyte counts

Baseline laboratory values must be submitted

Will medical records (e.g., chart notes) documenting patient's current height and weight be submitted? ❑ **Yes** ❑ **No**

Medical records (e.g., chart notes) must be submitted

Is the prescribed dose based on patient's ideal body weight? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization, please answer the following:

Will Revcovi be used in combination with Adagen (pegademase-bovine)? ❑ **Yes** ❑ **No**

Does the patient have a marked elevation of the metabolite dATP or total dAdo nucleotides (the sum of dAMP, dADP and dATP) in erythrocytes? ❑ **Yes** ❑ **No**

Is the patient **NOT** a candidate for or has failed hematopoietic cell transplantation (HCT)? ❑ **Yes** ❑ **No**

Does the patient have severe thrombocytopenia (< 50,000/mcL)? ❑ **Yes** ❑ **No**

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Revcovi™ Prior Authorization Request Form (Page 2 of 2)

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Will medical records (e.g., chart notes) documenting patient's current height and weight be submitted? ❑ **Yes** ❑ **No**
Medical records (e.g., chart notes) must be submitted

Is the prescribed dose based on patient's ideal body weight? ❑ **Yes** ❑ **No**

Has the patient experienced unacceptable toxicity from the drug (e.g., severe injection site reactions, bleeding, severe thrombocytopenia, etc.)? ❑ **Yes** ❑ **No**

Select if medical records (e.g., chart notes, laboratory values) documenting patient's disease stability and/or improvement as indicated by the following will be submitted:

- ❑ Increase in plasma ADA activity (target trough level greater than or equal to 15 mmol/hr/L)
- ❑ Red blood cell dATP level decreased (target less than or equal to 0.005 to 0.015 mmol/L)
- ❑ Improvement in immune function with diminished frequency/complications of infection as evidenced in improvement in the ability to produce antibodies
- ❑ Improvement in red blood cell dAXP levels (target trough level less than or equal to 0.02 mmol/L)

Medical records (e.g., chart notes, laboratory values) must be submitted

****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.

Prescriber Signature: _____ **Date:** _____

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: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.