HIGHMARK HEALTH OPTIONS

Updated: 04/2026
Approved: 04/2026

Request for Prior Authorization for Givlaari (givosiran)
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Givlaari (givosiran) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Givlaari (givosiran) Prior Authorization Criteria:

For all requests for Givlaari (givosiran) all of the following criteria must be met:

Coverage may be provided with a diagnosis of acute hepatic porphyria (AHP) and the following criteria is met:

- Member must be 18 years of age or older
- Must be prescribed by or in consultation with a provider who specializes in porphyria (i.e. hematologist, hepatologist, gastroenterologist)
- Member must have active disease defined as having at least 2 documented porphyria attacks requiring hospitalization, urgent care visits, or IV hemin administration within the last 6 months.
- Documentation the members has had elevated urinary or plasma porphobilinogen (PBG) or aminolevulinic acid (ALA) levels with the past year (reference range must be provided)
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Documentation of a decrease in the number of porphyria attacks that require hospitalization, urgent healthcare visits, or IV hemin administration since starting the medication.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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GIVLAARI (GIVOSIRAN) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE: _____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

Number of porphyria attacks within the last 6 months requiring hospitalization, urgent care visits, or IV hemin administration: _____ Date of attacks : _____

plasma porphobilinogen (PBG) level (please provide date taken and reference range): _____

aminolevulinic acid (ALA) level (please provide date taken and reference range): _____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Number of porphyria attacks within the last 6 months requiring hospitalization, urgent care visits, or IV hemin administration: _____ Date of attacks :

_____

Has the member experienced an improvement with treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date