Empaveli Clinical Profile Fax Form

24 Summit Park Drive
Pittsburgh, PA 15275
Phone: 888-258-1895
Fax: 866-609--1760

Physician:
Fax Number:

Date:

Patient Name:

DOB:

Please use this form to complete the Initial Referral process for EMPAVELI™. Please fax this completed form and any relevant clinical documentation (if applicable) attached to 1-866-609-1760. If you have any questions, please call 1-866-258-1895 and select Option 2 then Option 3 to speak with a pharmacist.

Please vaccinate patients against encapsulated bacteria as recommended at least 2 weeks prior to administering the first dose of EMPAVELI unless the risks of delaying therapy outweigh the risks of developing a serious infection.

Please advise patients of the risk of serious infection and inform patients that they are required to receive vaccinations against encapsulated bacteria at least 2 weeks prior to receiving the first dose of EMPAVELI if they have not been previously vaccinated.

To reduce the risk of hemolysis with abrupt treatment discontinuation:

- For patients switching from **eculizumab**, initiate **EMPAVELI** while continuing eculizumab at its current dose. After 4 weeks, discontinue **eculizumab** before continuing on monotherapy with **EMPAVELI**.
- For patients switching from **ravulizumab**, initiate **EMPAVELI** no more than 4 weeks after the last dose of **ravulizumab**.

Sincerely,

PANTHERx Rare Pharmacy
Care Team

CONFIDENTIALITY NOTE

ApellisAssist™

Patient Name: _____ **Date of Birth:** _____

IX. Patient Vaccine History/Prescription(s) (cont'd)

(to be completed by healthcare provider)

ACIP Recommendation for Patients With Complement Deficiency to Begin Treatment With EMPAVELI Current ACIP recommendations available at: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html		Vaccination History	Vaccine Prescription
***Meningococcal Conjugate* (MenACWY)**	• 2-dose series at least 8 weeks apart • Revaccinate every 5 years if risk remains	**Most Recent Brand Administered:** _____ **Most Recent Dose Date:** _____ **Most Recent Dose Characterization:** ☐ Series dose #1 ☐ Series dose #2 ☐ Booster **If MenACWY history is not available, please select below:** ☐ History Unknown ☐ Vaccine Not Received	**Rx:** ☐ Menactra® (MenACWY-D) ☐ Menveo® (MenACWY-CRM) ☐ MenQuadfi® (MenACWY-TT) **SIG:** _____ _____ **Quantity:** _____ **Refills #:** _____
***Serogroup B Meningococcal* (MenB)**	• 2-dose primary series MenB-4C at least 1 month apart **or** • 3-dose primary series MenB-FHbp at 0, 1-2, 6 months — If dose 2 was administered at least 6 months after dose 1, dose 3 is not needed ***Note:*** *MenB-4C (Bexsero) and MenB-FHbp (Trumenba) are* ***not*** *interchangeable (use same product for all doses in series).* • 1 dose booster 1 year after primary series • Revaccinate every 2-3 years if risk remains	**Most Recent Brand Administered:** _____ **Most Recent Dose Date:** _____ **Most Recent Dose Characterization:** ☐ Series dose #1 ☐ Series dose #2 ☐ Series dose #3 (Only applicable to Trumenba) ☐ Booster **If MenB history is not available, please select below:** ☐ History Unknown ☐ Vaccine Not Received	**Rx:** ☐ Bexsero® (MenB-4C) ☐ Trumenba® (MenB-FHbp) **SIG:** _____ _____ **Quantity:** _____ **Refills #:** _____

Prescriber Signature (Stamps not accepted)

Dispense as written: _____ Date: _____

Substitution permissible: _____ Date: _____

Prescriber NPI: _____

ApellisAssist™

Patient Name: _____ **Date of Birth:** _____

IX. Patient Vaccine History/Prescription(s) (cont'd)

(to be completed by healthcare provider)

ACIP Recommendation for Patients With Complement Deficiency to Begin Treatment With EMPAVELI Current ACIP recommendations available at: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html		Vaccination History	Vaccine Prescription
***Pneumococcal* PCV20, PCV15, PPSV23 & PCV13**	**2022 Updated Recommendations for Vaccine Naïve Adults and Unknown History:** • 1 dose **PCV20** **OR** • 1 dose **PCV15** followed by 1 dose **PPSV23** at least 8 weeks later **Previous PCV13/PPSV23 Recommendations:** • 1 dose ~~PCV13~~ followed by 1 dose ~~PPSV23~~ at least 8 weeks later • 1 dose **PPSV23** at least 5 years after previous ~~PPSV23~~ dose — Age 65 years or older, administer 1 dose PPSV23 at least 5 years after most recent PPSV23 if 1st dose administered prior to age 65 ***Note:*** *only 1 dose PPSV23 recommended at age 65 years or older.*	**PCV20:** Dose #1 Date: _____ **If PCV20 history is not available, please select below:** ☐ History Unknown ☐ Vaccine Not Received **PCV15:** Dose #1 Date: _____ **If PCV15 history is not available, please select below:** ☐ History Unknown ☐ Vaccine Not Received **PPSV23:** **Most Recent Dose Date:** _____ **Most Recent Dose Characterization:** ☐ Series dose #1 ☐ Series dose #2 ☐ Series dose #3 (for 65+) **If PPSV23 history is not available, please select below:** ☐ History Unknown ☐ Vaccine Not Received **PCV13:** Dose #1 Date: _____ **If PCV13 history is not available, please select below:** ☐ History Unknown ☐ Vaccine Not Received	**Rx:** ☐ Prevnar 20® (PCV20) **SIG:** _____ _____ **Quantity:** _____ **Rx:** ☐ Vaxneuvance® (PCV15) **SIG:** _____ _____ **Quantity:** _____ **Rx:** ☐ Pneumovax® (PPSV23) **SIG:** _____ _____ **Quantity:** _____ **Rx:** ☐ Prevnar 13® (PCV13) **SIG:** _____ _____ **Quantity:** _____

Prescriber Signature (Stamps not accepted)

Dispense as written: _____ Date: _____

Substitution permissible: _____ Date: _____

Prescriber NPI: _____

IX. Patient Vaccine History/Prescription(s) (cont'd)

(to be completed by healthcare provider)

ACIP Recommendation for Patients With Complement Deficiency to Begin Treatment With EMPAVELI Current ACIP recommendations available at: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html		Vaccination History	Vaccine Prescription
***Haemophilus influenzae* type B (Hib)**	• Recommended vaccination for adults who meet the age requirement **and** lack documentation of vaccination or lack evidence of past infection • If patients lack documentation of childhood vaccines 1 dose of Hib is recommended	**Most Recent Dose Date:** _____ **Most Recent Dose Characterization:** ☐ Last Dose of Pediatric Series ☐ Adult Dose #1 (for patients without childhood records) **If Hib history is not available, please select below:** ☐ History Unknown ☐ Vaccine Not Received	**Rx:** ☐ ActHIB® ☐ Hiberix® ☐ PedvaxHIB® **SIG:** _____ _____ **Quantity:** _____

If prophylactic antibiotic was prescribed with EMPAVELI outside of this form, please indicate anticipated antibiotic start date:

Date: _____

Prescriber Signature (Stamps not accepted)

Dispense as written: _____ Date: _____

Substitution permissible: _____ Date: _____

Prescriber NPI: _____

Table completed above is accurate based on my clinical and professional judgment. Please select one option:

SHIP AS SOON AS POSSIBLE - NO PRESCRIBER HOLD

☐ I have reviewed the EMPAVELI vaccination requirements and my patient's vaccination history and certify that my patient has been or will be vaccinated or will receive prophylactic antibiotic prior to beginning treatment with EMPAVELI and PANTHERx is authorized to dispense as soon as possible.

OR

HOLD SHIPMENT - CONTACT OFFICE PRIOR TO DISPENSE

☐ I have reviewed the EMPAVELI vaccination requirements and my patient's vaccination history, and I request that the EMPAVELI shipment be **held**, with additional follow-up to your office to confirm appropriate timing for dispense and allow for administration of missing vaccinations, prescribed above or to alternate provider.

Prescriber Signature (Stamps not accepted)

Sign here: _____ Date: _____