Empaveli Clinical Profile Fax Form

PANTHERx Rare Pharmacy
121 Bayer Road, Building 5
Pittsburgh, PA 15205
Phone: 866-258-1895 Fax: 866-609-1760

Physician:
Fax Number:

Date/Time:

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.

Vaccine Brand	ACIP Recommendation for Patients with Complement Deficiency	Dose in Series (Administration Date)
Meningococcal Conjugate Vaccine (MenACWY) Vaccination History		
☐ Menactra® (MenACWY-D) ☐ Menveo ® (MenACWY-CRM) ☐ MenQuadfi® (MenACWY-TT)	Administer a 2-dose series of MenACWY (Menactra, Menveo, or MenQuadfi) at least 8 weeks apart and revaccinate every 5 years if risk remains.	☐ Dose #1 (Date: _____) ☐ Dose #2 (Date: _____) ☐ Boosters (if applicable) (Most Recent Dose Date: _____)
Serogroup B Meningococcal Vaccination History		
☐ Bexsero® (MenB-4C) ☐ Trumenba® (MenB-FHbp)	Administer 2-dose primary series MenB-4C (Bexsero) at least 1 month apart or 3-dose primary series MenB-FHbp (Trumenba) at 0, 1-2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed. MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series). 1 dose MenB booster 1 year after primary series and revaccinate every 2-3 years if risk remains.	☐ Dose #1 (Date: _____) ☐ Dose #2 (Date: _____) ☐ Dose #3 (if applicable) (Date: _____) ☐ Boosters (if applicable) (Most Recent Dose Date: _____)
Pneumococcal PCV13 Vaccination History		
☐ Prevnar 13® (PCV13)	1 dose PCV13 followed by 1 dose PPSV23 at least 8 weeks later, then another dose PPSV23 at least 5 years after previous PPSV23; at age 65 years or older, administer 1 dose PPSV23 at least 5 years after most PPSV23 (note: only 1 dose PPSV23 recommended at age 65 years or older.	☐ Dose #1 (Date: _____)
Pneumococcal PPSV23 Vaccination History		

☐ Pneumovax® (PPSV23)	1 dose PCV13 followed by 1 dose PPSV23 at least 8 weeks later, then another dose PPSV23 at least 5 years after previous PPSV23; at age 65 years or older, administer 1 dose PPSV23 at least 5 years after most PPSV23 (note: only 1 dose PPSV23 recommended at age 65 years or older.	☐ Dose #1 (Date: _____) ☐ Dose #2 (if applicable) (Date: _____) ☐ Dose #3 (if applicable) (Date: _____)
Haemophilus *influenza* type B (Hib) Vaccination History		
☐ ActHIB® ☐ Hiberix® ☐ PedvaxHIB®	This is a 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 typical childhood scheduled/catch up vaccination, 1 dose of Hib (ActHIB, Hiberix, or PedvaxHIB)	☐ Dose #1 (Date: _____) ☐ Dose #2 (if applicable) (Date: _____) ☐ Dose #3 (if applicable) (Date: _____) ☐ Dose #4 (if applicable) (Date: _____)

1. **PNH Diagnosis Date:** Date when patient was first diagnosed with PNH (month/day/year) _____

1. **Most Recent/Current Therapy:** Current treatment prior to product switch to EMPAVELI™

☐ Eculizumab (Soliris®) ☐ Raculizumab-cwvz (Ultomiris®) ☐ pegcetacoplan (EMPAVELI™) (clinical trial)
☐ No prior complement inhibitor therapy prior to planned EMPAVELI™ start
☐ Other (please specify) _____

2. **Prior Therapy Dose and Frequency: C**urrent treatment dose and frequency prior to product switch to Empaveli

Dose:

☐ 900 mg (Soliris®)
☐ 3,000 mg (40kg to < 60kg Ultomiris®)
☐ 3,300 mg (60kg to < 100kg Ultomiris®)
☐ 3,600 mg (≥ 100kg Ultomiris®)
☐ Other (please specify) _____ mg

Frequency:

☐ Once every 2 weeks
☐ Once every 8 weeks
☐ Other (please specify) _____
_____

3. **Prior Therapy Start:** Current therapy start date prior to product switch to EMPAVELI™ _____

4. **Years on Complement Inhibitor Therapy:** Number of years on complement inhibitor therapy _____

5. **Current Therapy Most Recent Dose:** Date of most recent dose for current therapy _____

6. **Anticipated Start Date of EMPAVELI™:** What date do you anticipate the patient will start therapy with EMPAVELI™ (month/day/year) _____

7. **Anticipated Last Dose Date of Current Therapy:** Anticipated last scheduled dose of current complement inhibitor therapy, based upon your current targeted start date of EMPAVELI™ (month/day/year) _____

8. **Hemoglobin:** Most recent hemoglobin value prior to starting EMPAVELI™_____ (g/dL)

9. **Bilirubin:** Most recent bilirubin value prior to starting EMPAVELI™_____ (µmol/L)

10. **Reticulocyte Count:** Most recent reticulocyte count prior to starting EMPAVELI™_____ (10x9 cells/L)

11. **LDH level:** Most recent lactate dehydrogenase value prior to starting EMPAVELI™ _____ (unit/L)

12. **Transfusion History:** Number of transfusions within 6 months prior to starting EMPAVELI™ _____

13. **Breakthrough Hemolysis History:** Number of breakthrough hemolysis events within 6 months prior to starting EMPAVELI™ _____

14. **Thrombosis History:** Number of thrombotic events within 6 months prior to starting EMPAVELI™ _____

CONFIDENTIALITY NOTE