BlueCross BlueShield Federal Employee Program

AQNEURSA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

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.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Aqneursa

(levacetylleucine)

****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

1. Is this request for brand or generic? ❑Brand ❑Generic

2. Will the patient need more than 336 packets for oral suspension every 84 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ packets for oral suspension every 84 days

3. Does the patient have a diagnosis of Niemann-Pick disease type C (NPC)? ❑Yes ❑No

4. What is the patient's weight? _____ kg **OR** _____ lbs

5. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following question:
   - a. Has the NPC diagnosis been confirmed by genetic testing identifying disease-causing variants in the NPC1 or NPC2 genes? ❑Yes ❑No
   - b. Is Aqneursa being used for the neurological manifestations of NPC? ❑Yes ❑No
   - c. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes*** (*If YES, please answer the below questions)*** ❑No
     - i. Will pregnancy be excluded before initiating treatment with Aqneursa? ❑Yes ❑No
     - ii. Will the patient be advised to use effective contraception during treatment with Aqneursa and for 1 week after the last dose? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   - a. Has the neurological manifestations improved or stabilized? ❑Yes ❑No
   - b. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No

     If YES, will the patient be advised to use effective contraception during treatment with Aqneursa and for 1 week after the last dose? ❑Yes ❑No