BlueCross BlueShield Federal Employee Program

BYLVAY
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					

Bylvay (odevixibat)

****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

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

Will the patient need more than 7,200 micrograms (7.2 milligrams) per day? ❑Yes* ❑No

If YES, please specify the requested milligrams per day: _____ mg per day

1. Does the patient have a diagnosis of pruritus? ❑Yes* ❑No

   If YES, is the pruritus associated with progressive familial intrahepatic cholestasis (PFIC)? ❑Yes ❑No*

   If NO, does the patient have a diagnosis of cholestatic pruritus associated with Alagille syndrome (ALGS)? ❑Yes ❑No

2. Does the prescriber agree to monitor liver function tests (LFTs) and serum fat-soluble vitamin (FSV) levels during treatment? ❑Yes ❑No

3. Does the patient have cirrhosis, clinically significant portal hypertension, or hepatic decompensation? ❑Yes ❑No

4. Has the patient been on Bylvay continuously for the last **6 months**, excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

   a. **PFIC Diagnosis**: Does the patient have PFIC type 2 with ABCB11 variants causing non-functional or complete absence of bile salt export pump protein? ❑Yes ❑No

   b. **Cholestatic Pruritus associated with ALGS Diagnosis**: Please answer the following questions:

      i. Has the patient's diagnosis been confirmed by genetic testing (e.g., JAGGED1 mutation)? ❑Yes ❑No

      ii. Does the patient have bile duct paucity? ❑Yes* ❑No

      If YES, does the patient have at least three major clinical features of ALGS such as cholestasis, cardiac defect, skeletal abnormality, ophthalmic abnormality, or characteristic facial features? ❑Yes ❑No

   c. Has the patient had baseline liver function tests (LFTs) and serum fat-soluble vitamin (FSV) levels performed? ❑Yes ❑No

   d. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to cholestyramine? ❑Yes ❑No

   e. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to rifampin? ❑Yes ❑No

   f. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to ursodeoxycholic acid (UDCA)? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

   a. Has the patient had improvement in pruritus symptoms, or observed improvement in scratching? ❑Yes ❑No