BlueCross BlueShield Federal Employee Program

CTEXLI
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					

Ctexli (chenodiol)

****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 270 tablets every 90 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ tablets every 90 days

1. Does the patient have a diagnosis of cerebrotendinous xanthomatosis (CTX)? ❑Yes ❑No

2. Does the prescriber agree to monitor the patient's ALT, AST, and bilirubin levels annually as clinically indicated? ❑Yes ❑No

3. 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 questions:

a. Will the patient's baseline ALT, AST, and bilirubin levels be obtained? ❑Yes ❑No

b. Has the patient's diagnosis been confirmed through genetic testing documenting pathogenic variants in the CYP27A1 gene? ❑Yes ❑No

c. Does the patient have an elevated pretreatment plasma cholestanol level and elevated levels of bile alcohol (i.e., 23s-pentol) in their urine? ❑Yes ❑No

d. Is this medication being prescribed or recommended by a prescriber who specializes in treatment of CTX? ❑Yes ❑No

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

a. Has the patient achieved or maintained a positive clinical response to therapy such as a decreased or stabilized level of bile alcohol, reduction in signs and symptoms of CTX, or a reduction in plasma cholestanol level? ❑Yes ❑No