



**BlueCross  
BlueShield**

Federal Employee Program

## EGRIFTA

### PRIOR APPROVAL REQUEST

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.

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

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R <input type="text"/>			Physician Signature:		
<b>PHYSICIAN COMPLETES</b>						

## Egrifta (tesamorelin)

**\*\*Check [www.fepblue.org/formulary](http://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

1. Does the patient have a diagnosis of HIV-associated lipodystrophy? ☐ Yes ☐ No\*

\*If NO, please specify the patient's diagnosis: \_\_\_\_\_

2. Is there evidence of active malignancy? ☐ Yes ☐ No

3. **FEMALE Patient:** Is the patient of reproductive potential? ☐ Yes\* ☐ No

\*If YES, has the patient had a negative pregnancy test? ☐ Yes ☐ No

4. Is the patient on concomitant antiretroviral therapy? ☐ Yes ☐ No

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. Does the patient have excess abdominal (visceral) fat? ☐ Yes ☐ No

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

a. Does the physician agree to monitor the patient's glucose? ☐ Yes ☐ No

b. Has there been a decrease in visceral adipose tissue (VAT) as shown by a decrease in waist circumference or CT scan? ☐ Yes ☐ No