BlueCross BlueShield
Federal Employee Program

ENDARI
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					

Endari

(L-glutamine oral powder)

***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

1. Does the patient have a diagnosis of sickle cell disease (SCD)? ❑Yes ❑No

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

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

   a. Does the patient have an intolerance or contraindication (i.e., renal, cardiovascular, GI) or have they had an inadequate treatment response to a 3 month trial of generic hydroxyurea? ❑Yes ❑No

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

   a. Has there been a reduction in the number of acute complications (i.e., blood transfusions, sickle cell crisis's, hospitalizations) of sickle cell disease since initiating therapy? ❑Yes ❑No