BlueCross BlueShield Federal Employee Program

GIVLAARI
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					

Givlaari (givosiran)

****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. What is the patient's diagnosis?
   - ❑ Acute hepatic porphyria (AHP)
   - ❑ Other ***(please specify)***: _____

2. Does the prescriber agree to monitor the patient's liver function tests (LFTs)? ❑Yes ❑No

3. Does the prescriber agree to monitor the patient's renal function? ❑Yes ❑No

4. 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. Has the patient's diagnosis been confirmed by an elevated porphobilinogen (PBG) or delta-aminolevulinic acid (ALA) concentration within the past year? ❑Yes ❑No

   b. Has the patient's diagnosis been confirmed by genetic confirmation of one of the following: hydroxymethylbilane synthase (HMBS), coproporphyrinogen oxidase (CPOX), protoporphyrinogen oxidase (PPOX), or ALA dehydratase (ALAD)? ❑Yes ❑No

   c. Does the patient have active, symptomatic disease with at least two porphyria attacks within the last 6 months? ❑Yes ❑No*****

      ****If NO***, is the patient currently receiving prophylactic hemin treatment due to a history of severe or frequent porphyria attacks? ❑Yes ❑No

   d. Have baseline urinary or plasma porphobilinogen (PBG) or delta-aminolevulinic acid (ALA) concentrations been obtained? ❑Yes ❑No

   e. Will the patient be concurrently receiving prophylactic hemin treatment? ❑Yes ❑No

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

   a. Has the patient had a clinical response to therapy as demonstrated by a reduction in the rate of porphyria attacks? ❑Yes ❑No*****

      ****If NO***, has the patient had a clinical response to therapy as demonstrated by a reduction in hemin requirements for acute attacks? ❑Yes ❑No

   b. Have porphobilinogen (PBG) or delta-aminolevulinic acid (ALA) concentrations increased from baseline? ❑Yes ❑No