BlueCross BlueShield Federal Employee Program

HYMPAVZI
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					

Hympavzi

(marstacimab-hncq)

****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

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

2. Will the patient need more than 24 injections every 84 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ injections every 84 days

3. Does the patient have a diagnosis of hemophilia A or hemophilia B? ***Please select answer below:***

   ❑ **Yes, hemophilia A**
   - a. Does the patient have a detectable level or documented history of factor VIII inhibitors? ❑Yes ❑No
   - b. 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:
       - i. Does the patient have severe factor VIII deficiency (factor level less than 1 percent) at baseline? ❑Yes ❑No
     - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
       - i. Has the patient had a clinical benefit from Hympavzi therapy such as reduced bleeding episodes? ❑Yes ❑No

   ❑ **Yes, hemophilia B**
   - a. Does the patient have a detectable level or documented history of factor IX inhibitors? ❑Yes ❑No
   - b. 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:
       - i. Does the patient have moderately severe to severe factor IX deficiency (factor level less than or equal to 2 percent) at baseline? ❑Yes ❑No
     - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
       - i. Has the patient had a clinical benefit from Hympavzi therapy such as reduced bleeding episodes? ❑Yes ❑No

   ❑ **No**

4. Will this medication be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? ❑Yes ❑No

5. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to use effective contraception during treatment with Hympavzi and for 2 months after the last dose? ❑Yes ❑No

