BlueCross BlueShield Federal Employee Program

SAPROPTERIN
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: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

For Standard and Basic Option patients GENERIC Kuvan (sapropterin) is a preferred product. Please consider prescribing a preferred product. Standard/Basic Option patients who switch to the preferred product will be eligible for 2 copays at no cost in the benefit year.

Sapropterin

NOTE: Form must be completed in its **entirety** for processing

Please select medication: ❑**Javygtor (sapropterin)** ❑**Kuvan (sapropterin)** ❑**Sapropterin**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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

BRAND Kuvan Request (Standard/Basic Option Patient): Would you like to switch the patient to the preferred product, sapropterin (**generic** Kuvan)? ❑Yes, switch to sapropterin (**generic** Kuvan) ❑No*

If NO,** does the patient have an intolerance or contraindication or have they had an inadequate treatment response to sapropterin (**generic** Kuvan)? ***Please select answer below:

❑**Yes** ***(specify result)***: _____

❑**No**: Is there a clinical reason for not trying sapropterin (**generic** Kuvan)? ❑Yes* ❑No

If YES, please specify: _____

1. What is the patient's diagnosis?
   - ❑ Phenylketonuria (PKU)
   - ❑ Other diagnosis ***(please specify):*** _____
2. Is the patient currently on a phenylalanine-restricted diet? ❑Yes ❑No
3. Will this medication be used in combination with Palynziq (pegvaliase-pqpz)? ❑Yes ❑No
4. Has the patient been on this medication continuously for the last **2 months**, excluding samples? ***Please select answer below:***

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

a. Does the prescriber agree to monitor phenylalanine levels? ❑Yes ❑No

b. Has a tetrahydrobiopterin (BH_4) deficiency been ruled out? ❑Yes ❑No

c. **Sapropterin (GENERIC Kuvan) Request (Standard/Basic Option Patient)**: Is sapropterin (**generic** Kuvan) being requested as a change from **BRAND** Kuvan or Javygtor to allow the member access to their copay? ❑Yes* ❑No

If YES, please select medication: ❑**Brand** Kuvan ❑Javygtor

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

a. Has there been a baseline reduction in phenylalanine levels from baseline by 30% or greater? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***