



Federal Employee Program.

## LOARGYS 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                                                                  |      |  | Physician Signature:            |        |             |
| PHYSICIAN COMPLETES            |                                                                    |      |  |                                 |        |             |

### Loargys (pegzilarginase-nbln)

**\*\*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 Arginase 1 deficiency (ARG1-D)? ☐ Yes ☐ No
2. Will the patient be monitored for hypersensitivity reactions including anaphylaxis? ☐ Yes ☐ No
3. Will this medication be used in conjunction with dietary protein restriction? ☐ Yes ☐ No