BlueCross BlueShield Federal Employee Program

POTASSIUM BINDERS
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 provider 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					

Potassium Binders

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

Please select strength and indicate quantity:

Lokelma (sodium zirconium cyclosilicate):

❑5 gm quantity _____ packet(s) every 90 days **❑10 gm quantity _____ packet(s) every 90 days**

Veltassa (patiromer):

❑1 gm quantity _____ packet(s) every 90 days **❑16.8 gm quantity _____ packet(s) every 90 days**

❑8.4 gm quantity _____ packet(s) every 90 days **❑25.2 gm quantity _____ packet(s) every 90 days**

****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

1. Does the patient have a diagnosis of hyperkalemia? ❑Yes ❑No

2. Does the patient have chronic kidney disease (CKD)? ❑Yes ❑No*

   ***If NO,** please answer the following questions:

   a. Is the patient taking a medication that can cause hyperkalemia such as an ACE inhibitor, ARB, aldosterone antagonist, or potassium-sparing diuretic? ❑Yes ❑No

   b. Is there a therapeutic alternative to the specified medication that the patient could use? ❑Yes ❑No*

      ***If NO**, is the patient using the lowest effective dose of the specified medication? ❑Yes ❑No

4. Is the patient on a low potassium diet (2-3 grams per day)? ❑Yes ❑No

5. Does the prescriber agree to adjust the dose based on the serum potassium level? ❑Yes ❑No

6. Does the prescriber agree to **NOT** use this medication as emergency treatment for life-threatening hyperkalemia? ❑Yes ❑No

7. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ❑Yes ❑No*

   ***If NO**, does the patient have a contraindication or have they had either an inadequate response or intolerance to a loop or thiazide diuretic? ❑Yes ❑No

8. Will this medication be used in combination with another potassium binder such as Lokelma or Veltassa? ❑Yes* ❑No

   ***If YES**, please specify the medication: _____