BlueCross BlueShield Federal Employee Program

NASCOBAL
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder 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					

Nascobal (cyanocobalamin)

****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. Will the patient need more than 12 single-use sprays every 84 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ single-use sprays every 84 days

2. What is the patient's diagnosis?
   ❑Pernicious anemia
   a. Is there nervous system involvement? ❑Yes ❑No
   b. Has the patient been on Nascobal continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   i. Is the patient in remission following intramuscular (IM) vitamin B_{12} therapy? ❑Yes ❑No
   ii. Will Nascobal be used as maintenance therapy? ❑Yes ❑No
   iii. Have baseline levels of hematocrit, reticulocyte count, vitamin B_{12}, folate and iron levels been obtained? ❑Yes ❑No
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   i. Does the patient continue to be in remission following intramuscular (IM) vitamin B_{12} therapy? ❑Yes ❑No
   ❑Vitamin B_{12} deficiency
   a. Is Nascobal being used as treatment for vitamin B_{12} deficiency due to pernicious anemia? ❑Yes* ❑No**
   If YES, please complete the *Pernicious anemia* section above.
   ****If NO***, is Nascobal being used as treatment of dietary, drug-induced, or malabsorption-related vitamin B_{12} deficiency? ❑Yes ❑No
   b. Is Nascobal being used for the prevention of vitamin B_{12} deficiency? ❑Yes* ❑No
   If YES, does the patient have higher vitamin B_{12} requirements than normal? ❑Yes ❑No
   c. Has the patient been on Nascobal continuously for the last **6 months**, excluding samples? ❑Yes ❑No*
   If NO, have baseline levels of hematocrit, reticulocyte count, vitamin B_{12}, folate and iron levels been obtained? ❑Yes ❑No
   ❑Other diagnosis ***(please specify)***: _____

3. Does the prescriber agree to monitor platelet count, potassium, and serum B_{12} levels periodically? ❑Yes ❑No

4. Will Nascobal be used for the vitamin B_{12} absorption test (Schilling test)? ❑Yes ❑No

5. Does the patient have active symptoms of nasal congestion, allergic rhinitis, or upper respiratory infection? ❑Yes ❑No

6. Does the patient have a diagnosis of Leber's disease (hereditary optic nerve atrophy)? ❑Yes ❑No