BlueCross BlueShield Federal Employee Program

PIASKY
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					

Piasky (crovalimab-akkz)

****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. Does the patient have a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)? ❑Yes ❑No

2. Is the prescriber enrolled in the Piasky REMS program? ❑Yes ❑No

3. What is the patient's weight? _____ kg **OR** _____ lbs

4. Will this medication be used in combination with another Prior Authorization (PA) medication for PNH? ❑Yes* ❑No

   If YES, please specify medication: _____

5. 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 questions:

   i. Does the patient have a documented baseline value for serum LDH (lactate dehydrogenase)? ❑Yes ❑No

   ii. Has or will the patient be vaccinated against *Neisseria meningitidis* at least 2 weeks prior to initiating therapy? ❑Yes ❑No*

   If NO, is urgent Piasky therapy indicated for this patient (e.g. the risks of delaying treatment with Piasky outweigh the risk of developing Neisseria meningitidis)? ❑Yes ❑No

   iii. Will the patient need more than 9 vials for the loading doses? ❑Yes* ❑No

   If YES, please specify the requested quantity: _____ vials for the loading doses

   iv. After the initial loading doses, will the patient need more than 9 vials every 84 days? ❑Yes* ❑No

   If YES, please specify the requested quantity: _____ vials every 84 days

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

   i. Has the patient's serum LDH (lactate dehydrogenase) decreased from pretreatment baseline? ❑Yes ❑No

   ii. Has the patient experienced unacceptable toxicity while on the requested therapy? ❑Yes ❑No

   iii. Will the patient need more than 9 vials every 84 days? ❑Yes* ❑No

   If YES, please specify the requested quantity: _____ vials every 84 days

