BlueCross BlueShield Federal Employee Program

PROCYSBI
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 cardholder 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					

Procysbi

(cysteamine bitartrate)

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

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

1. Is the prescribing physician experienced in the management of nephropathic cystinosis, such as an endocrinologist, nephrologist or urologist? ❑Yes ❑No

2. Has the patient been on Procysbi therapy continuously for the last **6 months**, excluding samples? ***Select answer below:***

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

a. What is the patient's diagnosis?

❑Nephropathic cystinosis ❑Other diagnosis **(*please specify*):** _____

b. Has the diagnosis been confirmed by the presence of increased cystine concentration in the patient's leukocytes? ❑Yes ❑No

c. Has the patient had an inadequate response or intolerance to prior treatment with Cystagon, which is the immediate-release formulation? ❑Yes ❑No

d. Will the patient's white blood count (WBC) cystine levels or plasma cysteamine concentration be monitored in 2 weeks, and then quarterly for 6 months followed by twice a year at a minimum? ❑Yes ❑No

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

a. Is the patient still being treated for nephropathic cystinosis? ❑Yes ❑No

b. Will the patient's white blood count (WBC) cystine levels or plasma cysteamine concentration be monitored at least twice a year at minimum? ❑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 info 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 PA request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***