BlueCross BlueShield Federal Employee Program

PYRUKYND
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					

Pyrukynd (mitapivat)

****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

How many tablets will the patient need for an 84 day supply? _____ tablet(s) per 84 days

1. What is the patient's diagnosis?
   - ❑ Anemia
   - ❑ Hemolytic anemia with Pyruvate Kinase (PK) deficiency
   - ❑ Other diagnosis ***(please specify)***:_____
2. Does the prescriber agree to dose the patient based on hemoglobin levels and transfusion requirements? ❑Yes ❑No
3. Does the prescriber agree to taper the Pyrukynd dose with discontinuing therapy to reduce the risk of acute hemolysis? ❑Yes ❑No
4. Does the patient have moderate to severe hepatic impairment (Child-Pugh Class B or C)? ❑Yes ❑No
5. Has the patient been on Pyrukynd continuously for the last **4 months**, excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   - a. Has the patient's condition been confirmed by a PK deficiency test **OR** a mutation in the PKLR gene? ❑Yes ❑No
   - b. Does the prescriber agree to discontinue treatment with Pyrukynd if no clinical benefit is observed by 24 weeks? ❑Yes ❑No
   - c. What is the patient's hemoglobin level? _____ g/dL **OR** ❑Level unknown
   - d. Has the patient had 6 or more red blood cell (RBC) transfusion episodes in the last 52 weeks (1 year)? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question(s):
   - a. Has there been an increase in the patient's hemoglobin level since initiating therapy with Pyrukynd? ❑Yes ❑No*

     If NO, has there been a reduction in the need for red blood cell (RBC) transfusion since initiating therapy with Pyrukynd? ❑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 information 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 Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***