BlueCross BlueShield Federal Employee Program

QFITLIA
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					

Qfitlia (fitusiran)

****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 hemophilia A or hemophilia B? ***Please select answer below:***
   - ❑ Hemophilia A
   - ❑ Hemophilia B
   - ❑ Other diagnosis, please specify: _____
2. Has the patient been on this medication continuously for last **6 months**, excluding samples? ***Please select answer below:***
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:
     a. Will this medication be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? ❑ Yes ❑ No
     b. Does the prescriber agree to monitor antithrombin activity prior to treatment and at weeks 4, 12, 20, and 24? ❑ Yes ❑ No
     c. Will the treatment be interrupted or discontinued if gallbladder disease occurs? ❑ Yes ❑ No
     d. Does the patient have a history of thrombophilia or thrombosis? ❑ Yes ❑ No
     e. Will the patient need more than 9 injections over the course of a year? ❑ Yes* ❑ No
        ***If YES**, please specify requested quantity: _____ injections over the course of a year.
   - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
     a. Has the patient had a clinical benefit from therapy with this medication such as reduced bleeding episodes? ❑ Yes ❑ No
     b. Will this medication be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? ❑ Yes ❑ No
     c. Does the prescriber agree to monitor antithrombin activity prior to and after any dose modifications? ❑ Yes ❑ No
     d. Will the treatment be interrupted or discontinued if gallbladder disease occurs? ❑ Yes ❑ No
     e. Will the patient need more than 9 injections over the course of a year? ❑ Yes* ❑ No
        ***If YES**, please specify requested quantity: _____ injections over the course of a year.

