BlueCross BlueShield

physician portion and submit this completed form

VALCYTE 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

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:	Sta	ate:	Zip:
Patient ID: R	Physician Signature:					
PHYSICIAN COMPLETES						

Valcyte (valganciclovir)

**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

Federal Employee Program.

- 1. Does the patient have a diagnosis of HIV? □Yes □No
- 2. What is the patient's diagnosis?
 - Prevention of cytomegalovirus (CMV) (either prophylaxis or preemptive therapy)
 - a. Is the patient post hematopoietic stem cell transplant (HSCT)? Yes No*
 - *If NO, is the patient post solid organ transplant (including heart, liver, lung, kidney, or pancreas)? Yes No
 - b. Has the patient been on Valcyte continuously for the last **6 months**, <u>excluding samples</u>? \Box Yes \forall No* **If NO*, is the patient a sero-negative recipient? \Box Yes* \Box No

NO, is the patient a sero-negative recipient? $\Box Yes^*$ $\Box NO$

*If YES, was the donor sero-negative or sero-positive? Gero-negative Gero-positive

Treatment of cytomegalovirus (CMV)

a. Is the patient symptomatic? \Box Yes \Box No

□ Other diagnosis (*please specify*): ____

3. Does the patient have a platelet count greater than or equal to 25,000 platelets per microliter? \Box Yes \Box No

- 4. Does the patient have a hemoglobin greater than or equal to 8 grams per deciliter (g/dL)? \Box Yes \Box No
- 5. Does the patient have an absolute neutrophil count (ANC) greater than or equal to 500 cells per microliter? \Box Yes \Box No
- 6. Will Valcyte be used in combination with maribavir (Livtencity)? \Box Yes \Box No



BlueShield. VALCYTE Federal Employee Program. PRIOR APPROVAL REQUEST

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. <u>Please only fax the completed form once as</u> <u>duplicate submissions may delay processing</u> <u>times.</u>



The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** Lertify all information provided on this form to be true and correct to the best of my knowledge and belief. Lunderstand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and lagree to provide any such information to the insurer. Valcyte – FEP MD Fax Form Revised 9/6/2024