BlueCross BlueShield Federal Employee Program®

SABRIL / VIGADRONE / VIGAFYDE 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

For Standard and Basic Option patients, vigabatrin and Vigadrone are preferred products. Standard and Basic Option patients who switch to vigabatrin or Vigadrone will be eligible for 2 copays at no cost in the benefit year.

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

Please select medication: ❑**Sabril (vigabatrin)** ❑**Vigadrone (vigabatrin)** ❑**Vigafyde (vigabatrin)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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

1. **Sabril or Vigafyde Request (Standard Option patient)**: Please answer the following questions:
   a. Would you like to participate in this program and switch the patient to vigabatrin or Vigadrone? ***Select answer below:***
   - ❑**Yes, switch the patient to vigabatrin.**
   - ❑**Yes, switch the patient to Vigadrone.**
   - ❑**No**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to BOTH preferred medications vigabatrin and Vigadrone? ❑Yes ❑No*

     ***If NO,** is there a clinical reason for not trying BOTH preferred medications vigabatrin and Vigadrone? ❑Yes ❑No

2. **Vigafyde Request (Basic Option patient)**: Please answer the following questions:
   a. Would you like to participate in this program and switch the patient to vigabatrin or Vigadrone? ***Select answer below:***
   - ❑**Yes, switch the patient to vigabatrin.**
   - ❑**Yes, switch the patient to Vigadrone.**
   - ❑**No**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to BOTH preferred medications vigabatrin and Vigadrone? ❑Yes ❑No*

     ***If NO,** is there a clinical reason for not trying BOTH preferred medications vigabatrin and Vigadrone? ❑Yes ❑No

3. **Vigadrone or vigabatrin Request (Standard Option Patient)**: Is this medication being requested as a change from Sabril or Vigafyde to allow the member access to their copay benefit? ❑Yes, change from Sabril. ❑Yes, change from vigabatrin. ❑No

4. **Vigadrone or vigabatrin Request (Basic Option Patient)**: Is this medication being requested as a change from Vigafyde to allow the member access to their copay benefit? ❑Yes, change from vigabatrin. ❑No

5. Are the patient and prescriber enrolled in the Vigabatrin REMS program? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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Patient Name: _____ DOB: _____ Patient ID: R _____

6. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Select answer below:***

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

a. Does the prescriber agree to obtain a baseline vision assessment and assess every three months during therapy? ❑Yes ❑No

b. What is the patient's diagnosis?

❑ Infantile spasms

i. Will this medication be used as monotherapy? ❑Yes ❑No

❑ Refractory complex partial seizures (CPS)

i. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to alternative treatments? ❑Yes ❑No

❑ None of the above

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

a. Will the patient's vision be assessed every three months during therapy? ❑Yes ❑No

b. What is the patient's diagnosis?

❑ Infantile spasms

i. Will this medication be used as monotherapy? ❑Yes ❑No

❑ Refractory complex partial seizures (CPS)

❑ None of the above