BlueCross BlueShield Federal Employee Program

VIJOICE
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					

Vijoice (alpelisib)

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

Please select strength and provide quantity:

❑**50 mg blister packs (one 50mg tablet daily)**	**quantity _____ every 84 days**
❑**125 mg blister packs (one 125mg tablet daily)**	**quantity _____ every 84 days**
❑**250 mg blister packs (one 200mg tablet and one 50mg tablet daily)**	**quantity _____ every 84 days**
❑**50 granules**	**quantity _____ every 84 days**

****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. Does the patient have a diagnosis of PIK3CA-related overgrowth spectrum (PROS)? ❑Yes ❑No
2. Does the patient have a confirmed mutation in the PIK3CA gene? ❑Yes ❑No
3. Does the prescriber agree to monitor for severe cutaneous reactions such as Stevens-Johnson syndrome (SJS), erythema multiforme (EM), toxic epidermal necrolysis (TEN), and drug reaction with eosinophilia and systemic symptoms (DRESS)? ❑Yes ❑No
4. Does the prescriber agree to monitor for pneumonitis? ❑Yes ❑No
5. Does the prescriber agree to monitor for elevated glucose and decrease the dose or discontinue therapy as required? ❑Yes ❑No
6. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to use effective contraception during treatment with Vijoice and for 1 week after the last dose? ❑Yes ❑No
7. **MALE Patient**: Does the patient have a female partner of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to use condoms and effective contraception during treatment with Vijoice and for 1 week after the last dose? ❑Yes ❑No
8. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the following question:
   a. Does the patient have severe clinical manifestations and requires systemic treatment? ❑Yes ❑No
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑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.***

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:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand 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 I agree to provide any such information to the insurer. Vijoice – FEP MD Fax Form Revised 7/19/2024