BlueCross BlueShield Federal Employee Program.

VOXZOGO
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					

Voxzogo (vosoritide)

****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. Will the patient need more than 90 vials every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ vials per 90 days

2. Does the patient have a diagnosis of achondroplasia? ❑Yes ❑No

3. Does the patient have open epiphyses, confirmed by diagnostic imagining? ❑Yes ❑No

4. Does the prescriber agree to monitor the patient's body weight, growth, and physical development? ❑Yes ❑No

5. Does the prescriber agree to advise the patient and/or the patient's caregivers to have adequate food intake and 240-300 milliliters of fluid in the hour prior to administration? ❑Yes ❑No

6. Does the prescriber agree to discontinue Voxzogo upon confirmation of no further growth potential such as closure of epiphyses? ❑Yes ❑No

7. Is Voxzogo prescribed by or recommended by an endocrinologist or a prescriber with experience treating achondroplasia? ❑Yes ❑No

8. Will Voxzogo be used in combination with a growth hormone agent? ❑Yes* ❑No
   If YES, please specify the medication: _____

9. Has the patient been on Voxzogo continuously for the last **6 months**, excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following question:
   a. Has the patient's diagnosis been confirmed by genetic testing for the FGFR3 mutation? ❑Yes ❑No*
   If NO, has the patient's diagnosis been confirmed by X-ray findings and clinical symptoms, such as short stature with marked shortening of extremities, consistent with achondroplasia? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Has the patient had clinical benefit, such as increased linear growth, while on 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.***