BlueCross BlueShield
Federal Employee Program

VOYDEYA
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					

Voydeya
(danicopan)

****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 600 milligrams per day? ❑Yes* ❑No
   If YES, please specify the requested milligrams per day: _____ mg per day

2. Does the patient have a diagnosis of extravascular hemolysis associated with paroxysmal nocturnal hemoglobinuria (PNH)? ❑Yes ❑No

3. Are the patient and prescriber enrolled in the Voydeya REMS program? ❑Yes ❑No

4. Will this medication be used in combination with Soliris (eculizumab) or Ultomiris (ravulizumab)? ***Please select answer below:***
   ❑Yes, used in combination with Soliris (eculizumab).
   ❑Yes, used in combination with Ultomiris (ravulizumab).
   ❑No

5. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   a. Has or will the patient be vaccinated against encapsulated bacteria, including Streptococcus pneumoniae, Neisseria meningitidis, and Haemophilus influenzae type B at least 2 weeks prior to initiating therapy? ❑Yes ❑No*
      If NO, is urgent Voydeya therapy indicated for this patient (e.g. the risks of delaying treatment with Voydeya outweigh the risk of developing bacterial meningitis)? ❑Yes ❑No
   b. Does the patient have a documented baseline value for hemoglobin (Hgb)? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   a. Has the patient experienced unacceptable toxicity while on the requested therapy? ❑Yes ❑No
   b. Has the patient had an increase in hemoglobin (Hgb) from pretreatment baseline? ❑Yes ❑No

