BlueCross BlueShield
Federal Employee Program

VOYXACT
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			

Voyxact (sibeprenlimab-szsi) injection

***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

Will the patient need more than 3 syringes every 84 days? ❑Yes* ❑No
If YES, please specify the requested quantity: _____ syringes every 84 days

1. Does the patient have a diagnosis of primary immunoglobulin A nephropathy (IgAN)? ❑Yes ❑No

2. 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 questions:

a. Has the diagnosis been confirmed by a kidney biopsy? ❑Yes ❑No

b. Is the patient at risk for disease progression as indicated by proteinuria greater than or equal to 1.0 grams per day? ❑Yes ❑No

c. Does the patient have an eGFR greater than or equal to 30 milliliters per minute per 1.73 meters squared ($mL/min/1.73m^2$)? ❑Yes ❑No

d. Is this medication being prescribed by or recommended by a nephrologist? ❑Yes ❑No

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

a. Has there been a decrease in proteinuria?

3. Will this medication be used in combination with the maximum recommended or maximum tolerated dose of ACEI or ARB therapy? ❑Yes ❑No