BlueCross BlueShield Federal Employee Program

VYKAT XR
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					

Vykat XR (diazoxide choline)

****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 525 milligrams per day? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ milligrams per day

1. Does the patient have a diagnosis of Prader-Willi syndrome (PWS)? ❑Yes ❑No

2. Does the patient have moderate to severe hyperphagia (e.g., food obsession, aggressive food seeking behavior, lack of satiety)? ❑Yes ❑No

3. Does the prescriber agree to monitor for signs and symptoms of hyperglycemia and edema or fluid overload during treatment and as clinically indicated? ❑Yes ❑No

4. 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 patient's diagnosis been confirmed by genetic testing demonstrating ONE of the following, ***please select answer below:***
- ❑ Deletion in the chromosomal 15q11-q13 region
- ❑ Maternal uniparental disomy in chromosome 15
- ❑ Imprinting defects, translocations, or inversions involving chromosome 15

b. Is this medication being prescribed by, or recommended by, an endocrinologist? ❑Yes ❑No

c. Will the patient's fasting glucose and HbA1c be tested prior to initiation of therapy? ❑Yes ❑No

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

a. Has the patient had improvement in the symptoms of hyperphagia? ❑Yes ❑No