BlueCross BlueShield
Federal Employee Program

XROMI
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

Xromi (hydroxyurea)

****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. Does the patient have a diagnosis of sickle cell disease (SCD)? ❑Yes ❑No*
   ***If NO**, please specify: _____
2. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
   (Examples include chickenpox/varicella, dengue, FluMist (intranasal flu nasal spray), MMR, rotavirus, smallpox, yellow fever, Zostavax etc.)
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. Does the patient have a history of moderate to severe painful crises? ❑Yes ❑No
   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to generic hydroxyurea? ❑Yes ❑No
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   a. Has the patient had a decrease in number of painful crises? ❑Yes ❑No
4. Does the prescriber agree to monitor blood counts at least every 4 weeks throughout therapy and adjust dose accordingly? ❑Yes ❑No
5. Does the prescriber agree to monitor for the development of secondary malignancies? ❑Yes ❑No
6. **MALE Patient**: Does the patient have a female partner of reproductive potential? ❑Yes* ❑No
   ***If YES**, will the patient be advised to use effective contraception during treatment and for at least 1 year after therapy? ❑Yes ❑No
7. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
   ***If YES**, will the patient be advised to use effective contraception during treatment and for at least 6 months after therapy? ❑Yes ❑No

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. Xromi – FEP MD Fax Form Revised 11/28/2025