BlueCross BlueShield
Federal Employee Program

YEZTUGO
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					

Yeztugo

(lenacapavir)

****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. Is this medication being used for pre-exposure prophylaxis (PrEP) of HIV-1 infection? ❑Yes ❑No
2. Has the prescriber counseled the patient regarding the required injection dosing schedule and the importance of adherence to scheduled dosing visits? ❑Yes ❑No
3. Is the patient at risk for sexually acquired HIV-1 infection? ❑Yes ❑No
4. Does the prescriber agree to confirm the patient is HIV-1 infection status negative before each injection? ❑Yes ❑No
5. Does the prescriber agree to transition the patient to a complete HIV-1 treatment regimen if the patient acquires HIV-1 infection during treatment with Yeztugo? ❑Yes ❑No
6. Has the patient's HIV-1 infection status been confirmed negative using a test cleared by the FDA for the diagnosis of acute or primary HIV-1 infection? ❑Yes ❑No
7. Will Yeztugo be administered by a healthcare professional? ❑Yes ❑No
8. What is the patient's weight? _____ kg **OR** _____ lbs
9. Is this **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***

❑ **INITIATION** of therapy, please answer the following question:

a. Will the patient need more than 4 tablets and 4 vials for 12 months of therapy? ❑Yes* ❑No
If YES, please specify the requested quantity: _____ tablets and _____ vials for 12 months of therapy

❑ **CONTINUATION** of therapy **(PA renewal)**, please answer the following question:

a. Will the patient need more than 4 vials for 12 months of therapy? ❑Yes* ❑No
If YES, please specify the requested quantity: _____ vials for 12 months of therapy