



Federal Employee Program.

**YUUIWEL
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						

Yuuiwel (navepegritide)

NOTE: Form must be completed in its **entirety** for processing

Please select strength:

☐ 1.3 mg	☐ 2.8 mg	☐ 5.5 mg
---------------------------------	---------------------------------	---------------------------------

**Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

Is this request for brand or generic? ☐ Brand ☐ Generic

- How many vials will the patient need every 84 days? _____ vial(s) every 84 days
- Does the patient have a diagnosis of achondroplasia? ☐ Yes ☐ No
- Does the prescriber agree to monitor the patient's body weight, growth, and physical development? ☐ Yes ☐ No
- Does the prescriber agree to discontinue Yuuiwel upon confirmation of no further growth potential such as closure of epiphyses? ☐ Yes ☐ No
- Does the patient have hemodynamically significant cardiovascular disease? ☐ Yes ☐ No
- Does the patient have open epiphyses confirmed by diagnostic imaging? ☐ Yes ☐ No
- Is this medication prescribed by or recommended by an endocrinologist or a prescriber with experience treating achondroplasia? ☐ Yes ☐ No
- Will this medication be used in combination with a growth hormone agent or another CNP analog for achondroplasia? ☐ Yes* ☐ No

*If YES, please specify the medication(s): _____

9. 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 for the FGFR3 mutation? ☐ Yes ☐ No*

*If NO, has the patient's diagnosis been confirmed by X-ray findings and clinical symptoms, such as short stature with marked shortening of extremities, consistent with achondroplasia? ☐ Yes ☐ No

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

- a. Has the patient had clinical benefit, such as increased linear growth, while on therapy? ☐ Yes ☐ No