BlueCross BlueShield Federal Employee Program®

# ZAVESCA / YARGESA
# 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** | | | | | |

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

**Please select medication:** ❑ **Zavesca (miglustat)** ❑ **Yargesa (miglustat)**

****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

1. What is the patient's diagnosis?

❑ Type 1 Gaucher disease

a. Will this medication be given in combination with another medication for Type 1 Gaucher disease? ❑Yes* ❑No

***If YES,** please specify the medication: _____

***Type 1 Gaucher Disease Medications: Cerdelga (eliglustat), Cerezyme (imiglucerase), Elelyso (taliglucerase alfa), VPRIV (velaglucerase alfa)**

b. 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 question(s):

i. Does the patient have mild-to-moderate Type 1 Gaucher disease? ❑Yes ❑No

ii. Is enzyme replacement therapy (such as Cerezyme, Elelyso, or VPRIV) a therapeutic option for the patient? ❑Yes ❑No

iii. Does the patient have constraints to therapy with an enzyme due to one or more of the following reasons: allergy, hypersensitivity, or poor venous access? ❑Yes* ❑No

***If YES,** please select the constraint below:

❑Allergy ❑Hypersensitivity ❑Poor venous access

❑Other reason ***(please specify)***: _____

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy.

❑ Niemann-Pick disease type C (NPC)

a. Will this medication be used in combination with Miplyffa (arimoclomol)? ❑Yes ❑No

b. 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 question(s):

i. Has the patient's diagnosis been confirmed by genetic testing identifying disease causing variants in the NPC1 or NPC2 genes? ❑Yes ❑No

ii. Is this medication being used for the neurological manifestations of NPC? ❑Yes ❑No

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

i. Have the patient's neurological manifestations improved or stabilized? ❑Yes ❑No

❑ Other diagnosis ***(please specify)***: _____

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. Zavesca Yargesa – FEP MD Fax Form Revised 1/17/2025