(Revised 1/2023)

blue of california

FEP PPO PRESCRIPTION DRUG PRIOR AUTHORIZATION Givlaari J0223

Plan/Medical Group Name: Blue Shield of California

Plan Phone#: (800) 633-4581

☐ **Non-Urgent-** The Federal Employee Program has a **72- hour turn-around time on medications that require Prior Authorization a**ccording to the Blue Cross Blue Shield Service Benefit Plan. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information **FAX TO: 844-224-0226**

☐ **Urgent Request-** Please note, scheduling issues do not meet the definition of Urgent. ***Definition of an Urgent Request:*** An imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision making might seriously jeopardize the life or health of the member. **FAX TO: 844-224-0226**

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____Weight (lb/kg):_	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information

Medication Name and HCPCS or CPT Code:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration: ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location: ☐ Physician's Office ☐ Outpatient Hospital Care	☐ Patient's Home ☐ Home Care Agency	☐ Long Term Care ☐ Ambulatory Infusion Center ☐ Other (explain):

PRESCRIPTION DRUG PRIOR AUTHORIZATION

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

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

1. What is the patient's diagnosis? ❑ Acute Hepatic Porphyria (AHP) ❑ Other diagnosis (please specify):
_____

2. Will a healthcare professional be available to administer Givlaari and give medical support if necessary for anaphylactic reactions? ❑Yes ❑No

3. Does the prescriber agree to monitor the patient's liver function tests (LFTs)? ❑Yes ❑No

4. Does the prescriber agree to monitor the patient's renal function? ❑Yes ❑No

5. Has the patient been on Givlaari continuously for the last 4 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 an elevated porphobilinogen (PBG) or delta-aminolevulinic acid (ALA) concentration? ❑Yes ❑No

b. Has the patient had genetic confirmation of the following: hydroxymethylbilane synthase (HMBS), coproporphyrinogen oxidase (CPOX), protoporphyrinogen oxidase (PPOX), or ALA dehydratase (ALAD) to confirm their diagnosis? ❑Yes ❑No

c. Does the patient have active, symptomatic disease with at least two documented porphyria attacks requiring acute care in the last six months? ❑Yes ❑No* *If NO, is the patient currently receiving prophylactic hemin treatment due to a history of severe or frequent porphyria attacks? ❑Yes ❑No

d. Have baseline urinary or plasma porphobilinogen (PBG) or delta-aminolevulinic acid (ALA) concentrations been obtained? ❑Yes ❑No

e. Will the patient be concurrently receiving prophylactic hemin treatment? ❑Yes ❑No ❑YES – **this is a PA renewal for CONTINUATION of therapy**, please answer the following questions:

a. Has the patient had a clinical response to therapy as demonstrated by a reduction in the rate of porphyria attacks?

❑Yes ❑No* *If NO, has the patient had a clinical response to therapy as demonstrated by a reduction in hemin requirements for acute attacks? ❑Yes ❑No

b. Have porphobilinogen (PBG) or delta-aminolevulinic acid (ALA) concentration increased from baseline? ❑Yes ❑No

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Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification:_____ **Date**:_____

Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer:_____ Date/Time of Decision_____
Fax Number (_____)_____

Approved Denied Comments/Information Requested: _____