BlueCross BlueShield Federal Employee Program

(givosiran) GIVLAARI PRIOR APPROVAL REQUEST

Send completed form to:
FAX: 855-895-3504
FOR URGENT FAX: 844-244-0226

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					

Givlaari (givosiran)

****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. 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