(Revised 1/2023)

blue of california

FEP PPO PRESCRIPTION DRUG PRIOR AUTHORIZATION Onpattro J0222

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** according 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.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances or required under state and federal laws.

Initial Auth:

1. 18 years of age and older **with** Diagnosis is Polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis ☐Yes☐No
2. Diagnosis of hATTR confirmed by a genetic test OR tissue biopsy showing amyloid deposition ☐Yes☐No
3. Patient must have ONE of the following baseline scores:
    a. Polyneuropathy disability (PND) score ≤ IIIb (see Appendix 1) ☐Yes☐No
    b. FAP Stage 1 or 2 (see Appendix 2) ☐Yes☐No
4. Will be administered by a healthcare professional ☐Yes☐No
5. Patient will receive premedication to reduce the risk of infusion-related reactions ☐Yes☐No
6. Prescriber agrees to supplement the patient with the recommended daily allowance of Vitamin A if indicated ☐Yes☐No
7. Patient has any the following:
    a. New York Heart Association (NYHA) class III or IV heart failure ☐Yes☐No
    b. Sensorimotor or autonomic neuropathy not related to hATTR amyloidosis (monoclonal gammopathy, autoimmune disease, etc.) ☐Yes☐No
    c. Prior liver transplantation ☐Yes☐No
8. Prescribed by or in consultation with a neurologist, or a specialist in the treatment of the patient's diagnosis ☐Yes☐No
9. Dual therapy with another Prior Authorization (PA) medication for polyneuropathy caused by hATTR amyloidosis ☐Yes☐No

Renewal Auth:

1. 18 years of age and older **with** Diagnosis is Polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis ☐Yes☐No
2. Patient condition has improved or stabilized ☐Yes☐No
3. Will be administered by a healthcare professional ☐Yes☐No
4. Patient will receive premedication to reduce the risk of infusion-related reactions ☐Yes☐No
5. Prescriber agrees to supplement the patient with the recommended daily allowance of Vitamin A if indicated ☐Yes☐No
6. Dual therapy with another Prior Authorization (PA) medication for polyneuropathy caused by hATTR amyloidosis ☐Yes☐No

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: _____