(Revised 01/2023)

blue of california

# FEP PPO PRESCRIPTION DRUG PRIOR AUTHORIZATION Oxlumo J0224

**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 requires 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.

1. Initial authorization requirements patient has diagnosis of primary hyperoxaluria confirmed by:

   a: by identification of biallelic pathogenic variants in alanine:glyoxylate aminotransferase (AGT or AGXT) gene OR liver biopsy demonstrating AGT deficiency ☐Yes☐No

   b: Presence of 1 of the following clinical signs or symptoms of PH1:

   ☐i: Elevated urine oxalate excretion (body surface area-normalized daily urine oxalate excretion output ≥ 0.7 mmol/1.73 m2)

   ☐ii: Elevated plasma oxalate concentration > 20 µmol/L or > 1.76 mg/L

   ☐iii. Urine oxalate excretion:creatinine ratio above age-specific upper limit of normal

   c. Patient has not received a liver or kidney transplant ☐Yes☐No

   d. Estimated glomerular filtration rate (eGFR) > 30 mL/min/1.73m2 ☐Yes☐No

   e. Prescribed by or in consultation with a nephrologist, urologist, geneticist, or any healthcare provider with expertise in treating primary hyperoxaluria type 1 ☐Yes☐No

   f. Patient will be dosed based on actual body weight ☐Yes☐No

   g. Prescriber agrees to monitor urinary oxalate levels☐Yes☐No

2. Renewal requirements patient has diagnosis of primary hyperoxaluria ☐Yes☐No

   a. Patient has had a clinically meaningful response to therapy from pre-treatment baseline (e.g., decreased urinary oxalate concentrations, decreased urinary oxalate:creatinine ratio, decreased plasma oxalate concentrations, improvement, stabilization or slowed worsening of nephrocalcinosis, renal stone events, renal impairment, or systemic calcinosis) ☐Yes☐No

   b. Patient has not received a liver or kidney transplant ☐Yes☐No

   c. Patient will be dosed based on actual body weight ☐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: _____