VIJOICE
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review
☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: ____________________

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** ____________________

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient diagnosis:

☐ PIK3CA-Related Overgrowth Spectrum (PROS)
☐ Other (ICD code and description): ____________________

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
2. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify contraindications to the requested agent: ____________________
3. Is the patient's age within FDA labeling for the requested diagnosis for the requested agent? ☐ Yes ☐ No
   If no, please provide support for using the requested agent for the patient's age for the requested indication: ____________________
4. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested indication? ☐ Yes ☐ No
   If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit? ☐ Yes ☐ No
   If yes, please explain why the requested dose cannot be optimized: ____________________
5. Is the prescriber a specialist in the area of patient's diagnosis (e.g., experienced in PROS) or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ☐ Yes ☐ No
6. Does the patient have severe manifestations of PROS that requires systemic therapy? ☐ Yes ☐ No
7. Does the patient have a diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS) confirmed by ALL of the following: 1) presence of somatic PIK3CA mutation (medical records required for review), 2) congenital or early childhood onset, AND 3) overgrowth sporadic and mosaic? **Please note, lab results and medical records are required.** ☐ Yes ☐ No
   If yes, does the patient have at least TWO of the following features: 1) overgrowth, 2) vascular malformations, and/or 3) epidermal nevus? ☐ Yes ☐ No
8. If no, does the patient have at least ONE of the following features: 1) large isolated lymphatic malformations, 2) isolated macrodactyly OR overgrown splayed feet/hands, overgrown limbs, 3) truncal adipose overgrowth, 4) Hemimegalencephaly (bilateral)/dysplastic megalencephaly/focal cortical dysplasia, 5) epidermal nevus, 6) seborrheic keratoses, and/or 7) benign lichenoid keratoses? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For renewal requests:

9. Has the patient had clinical benefit with the requested agent?.. ☐ Yes ☐ No
10. Has the patient had disease progression (e.g., increase in lesion number, increase in lesion volume) with the requested agent? **Please note, medical records are required.**.. ☐ Yes ☐ No

Please fax or mail this form to:
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Clinical Review Department
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Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
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BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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