BlueCross BlueShield Federal Employee Program

ADCETRIS
PRIOR APPROVAL REQUEST

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.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

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					

Adcetris (brentuximab vedotin)

****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. Does the prescriber agree to monitor the patient for the development of JC virus infection resulting in progressive multifocal leukoencephalopathy (PML) and to discontinue therapy if PML is confirmed? ❑Yes ❑No

2. What is the patient's diagnosis?
   - ❑Classical Hodgkin's lymphoma (cHL)
     - a. Has the patient been on Adcetris continuously for the last **6 months**, excluding samples? ***Please select answer below:***
       - ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
         - i. Does the patient have previously untreated stage III or IV classical Hodgkin's lymphoma? ❑Yes***** ❑No
           ****If YES***, will Adcetris be used in combination with doxorubicin, vinblastine, and dacarbazine? ❑Yes ❑No
         - ii. Does the patient have previously untreated high risk classical Hodgkin lymphoma? ❑Yes***** ❑No
           ****If YES***, will Adcetris be used in combination with doxorubicin, vincristine, etoposide, prednisone, and cyclophosphamide? ❑Yes ❑No
         - iii. Has the patient had an autologous hematopoietic stem cell transplant (auto-HSCT)? ***Please select answer below:***
           - ❑**Yes**: Has the patient experienced a failure of an auto-HSCT? ❑Yes ❑No*****
             ****If NO***, is the patient at high risk of relapse or progression post-auto-HSCT consolidation? ❑Yes ❑No
           - ❑**No**: Is the patient a candidate for an auto-HSCT? ❑Yes ❑No*****
             ****If NO,*** has the patient experienced a treatment failure of at least two prior multi-agent chemotherapy regimens? ❑Yes ❑No
       - ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
         - i. Has the patient experienced disease progression or unacceptable toxicity while on Adcetris? ❑Yes ❑No
   - ❑Mycosis fungoides (MF)
     - a. Does the patient have CD30-expressing mycosis fungoides? ❑Yes ❑No
     - b. Has the patient been on Adcetris continuously for the last **6 months**, excluding samples? ***Please select answer below:***
       - ❑**NO** – this is **INITIATION** of therapy, please answer the following question:
         - i. Has the patient received prior systemic therapy? ❑Yes ❑No
       - ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
         - i. Has the patient experienced disease progression or unacceptable toxicity while on Adcetris? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Peripheral T-cell lymphomas (PTCL) including angioimmunoblastic T-cell lymphoma and PTCL not otherwise specified

a. Does the patient have CD30-expressing peripheral T-cell lymphoma? ❑Yes ❑No

b. Has the patient been on Adcetris continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following question(s):

i. Has the patient been previously treated? ❑Yes ❑No*****

****If NO***, will Adcetris be given with cyclophosphamide, doxorubicin, and prednisone? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has the patient experienced disease progression or unacceptable toxicity while on Adcetris? ❑Yes ❑No

❑ Primary cutaneous anaplastic large cell lymphoma (pcALCL)

a. Has the patient been on Adcetris continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following question:

i. Has the patient received prior systemic therapy? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has the patient experienced disease progression or unacceptable toxicity while on Adcetris? ❑Yes ❑No

❑ Relapsed or refractory large B-cell lymphoma (LBCL) including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, diffuse large B-cell lymphoma (DLBCL) arising from indolent lymphoma, and high-grade B-cell lymphoma (HGBL)

a. Has the patient been on Adcetris continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Is the patient eligible for autologous hematopoietic stem cell transplantation (HSCT) or CAR T-cell therapy? ❑Yes ❑No

ii. Has the patient failed two or more lines of systemic therapy? ❑Yes ❑No

iii. Will Adcetris be used in combination with lenalidomide and a rituximab product? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has the patient experienced disease progression or unacceptable toxicity while on Adcetris? ❑Yes ❑No

❑ Systemic anaplastic large cell lymphoma (sALCL)

a. Has the patient been on Adcetris continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Has the patient been previously treated? ***Please select answer below:***

❑**Yes**: Has the patient failed a multi-agent chemotherapy regimen? ❑Yes ❑No

❑**No**: Will Adcetris be used in combination with cyclophosphamide, doxorubicin, and prednisone? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has the patient experienced disease progression or unacceptable toxicity while on Adcetris? ❑Yes ❑No

❑ Other diagnosis ***(please specify):*** _____