BlueCross BlueShield Federal Employee Program

AKEEGA
PRIOR APPROVAL REQUEST

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

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					

Akeega

(niraparib and abiraterone acetate)

****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. Will the patient need more than 180 tablets every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ tablets per 90 days

2. Does the patient have a diagnosis of metastatic castration-resistant prostate cancer (mCRPC)? ❑Yes ❑No

3. Does the prescriber agree to monitor the patient for cardiovascular effects? ❑Yes ❑No

4. Does the patient have a female partner of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to use effective contraception during treatment with Akeega and for 4 months after the last dose? ❑Yes ❑No

5. Will Akeega be used in combination with prednisone? ❑Yes ❑No

6. Will Akeega be used in combination with another androgen receptor inhibitor? ❑Yes* ❑No
   If YES, please specify the medication: _____

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

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   a. Does the patient have a deleterious or suspected deleterious BRCA mutation? ❑Yes ❑No
   b. Does the prescriber agree to obtain a complete blood count (CBC) at baseline, weekly for the first month, and monthly thereafter? ❑Yes ❑No
   c. Has the patient had a bilateral orchiectomy? ❑Yes ❑No
   d. Will the patient be receiving concurrent therapy with gonadotropin-releasing hormone (GnRH) analog? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   a. Does the prescriber agree to obtain complete blood counts (CBCs) as clinically indicated? ❑Yes ❑No
   b. Has the patient experienced disease progression or unacceptable toxicity while on Akeega? ❑Yes ❑No