BlueCross BlueShield Federal Employee Program

AUGTYRO
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					

Augtyro (repotrectinib)

****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 320 milligrams per day? ❑Yes* ❑No
   If YES, please specify the requested milligrams per day: _____ mg per day

2. Does the prescriber agree to monitor the patient's uric acid level and liver function tests (LFTs) including bilirubin? ❑Yes ❑No

3. **MALE Patient**: 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 Augtyro and for 4 months after the last dose? ❑Yes ❑No

4. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to use effective non-hormonal contraception during treatment with Augtyro and for 2 months after the last dose?

5. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   a. What is the patient diagnosis? ***Please select answer below:***
   ❑Locally advanced non-small cell lung cancer (NSCLC)
   i. Is the tumor positive for an ROS-1 mutation? ❑Yes ❑No
   ❑Solid tumors
   i. Has the disease progressed following treatment? ❑Yes ❑No*
   If NO, is there satisfactory alternative therapy for the solid tumors? ❑Yes ❑No
   ii. Is surgical resection likely to result in severe morbidity? ❑Yes ❑No*
   If NO, does the patient have locally advanced or metastatic solid tumors? ❑Yes ❑No
   iii. Does the patient have a NTRK (neurotrophic tyrosine receptor kinase) gene fusion? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   a. What is the patient diagnosis? ***Please select answer below:***
   ❑Locally advanced non-small cell lung cancer (NSCLC)
   ❑Solid tumors
   b. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No