BlueCross BlueShield Federal Employee Program

AVMAPKI FAKZYNJA CO-PACK 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 cardholder 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					

Avmapki Fakzynja Co-pack

(avutometinib/defactinib)

****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

Will the patient need more than 3 cartons every 84 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ cartons every 84 days

1. Does the patient have a diagnosis of recurrent low-grade serious ovarian cancer (LGSOC)? ❑Yes ❑No
2. 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. Is there a presence of a KRAS mutation in tumor specimens? ❑Yes ❑No
   b. Has the patient received prior systemic therapy? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Has the patient experienced disease progression or unacceptable toxicity? ❑Yes ❑No
3. Does the prescriber agree to monitor for ocular toxicities? ❑Yes ❑No
4. **FEMALE Patient:** Is the patient of reproductive potential? ❑Yes* ❑No

   If YES, will the patient be advised to use effective contraception during treatment with Avmapki Fakzynja Co-pack and for 1 month after the last dose? ❑Yes ❑No
5. **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 Avmapki Fakzynja Co-pack and for 4 months after the last dose? ❑Yes ❑No