BlueCross BlueShield Federal Employee Program.

BRUKINSA
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					

Brukinsa (zanubrutinib)

****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 360 capsules every 90 days? ❑Yes***** ❑No
   If YES, please specify the requested quantity: _____ capsules every 90 days
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 question:

a. What is the patient's diagnosis?

❑Chronic lymphocytic leukemia (CLL) ❑Small lymphocytic lymphoma (SLL)

❑Mantle cell lymphoma (MCL)

i. Has the patient received at least one prior therapy? ❑Yes ❑No

❑Relapsed or refractory follicular lymphoma (FL)

i. Will this medication be used in combination with Gazyva (obinutuzumab)? ❑Yes ❑No

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

❑Relapsed or refractory marginal zone lymphoma (MZL)

i. Has the patient received at least one anti-CD20-based regimen? ❑Yes ❑No

❑Waldenström's macroglobulinemia (WM)

❑Other ***(please specify)***: _____

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

a. What is the patient's diagnosis?

❑Chronic lymphocytic leukemia (CLL) ❑Relapsed or refractory marginal zone lymphoma (MZL)

❑Mantle cell lymphoma (MCL) ❑Small lymphocytic lymphoma (SLL)

❑Relapsed or refractory follicular lymphoma (FL)

i. Will this medication be used in combination with Gazyva (obinutuzumab)? ❑Yes ❑No

❑Waldenström's macroglobulinemia (WM)

❑Other ***(please specify)***: _____

b. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No

3. Does the prescriber agree to monitor for bleeding and malignancies? ❑Yes ❑No
4. Does the prescriber agree to monitor complete blood count (CBC) for cytopenias? ❑Yes ❑No
5. Does the prescriber agree to monitor for cardia arrhythmias? ❑Yes ❑No
6. **MALE Patient**: Does the patient have a female partner of reproductive potential? ❑Yes***** ❑No
   If YES, will the patient be advised not to father a child during treatment with Brukinsa and for at least 1 week after the last dose? ❑Yes ❑No
7. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No
   If YES, will the patient be advised not to become pregnant during treatment with Brukinsa and for at least 1 week after the last dose? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***