BlueCross BlueShield Federal Employee Program

COPIKTRA
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					

Copiktra (duvelisib)

***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 168 capsules every 84 days? ❑Yes***** ❑No

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

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

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

a. What is the patient's diagnosis?

❑Breast implant-associated anaplastic large cell lymphoma (ALCL)

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

i. Is the patient's diagnosis relapsed or refractory? ❑Yes ❑No

ii. Has the patient had at least two prior lines of systemic therapies? ❑Yes ❑No

❑Hepatosplenic T-Cell lymphoma

❑Peripheral T-Cell lymphoma (PTCL)

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

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

a. What is the patient's diagnosis?

❑Breast implant-associated anaplastic large cell lymphoma (ALCL)

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

i. Is the patient's diagnosis relapsed or refractory? ❑Yes ❑No

❑Hepatosplenic T-Cell lymphoma

❑Peripheral T-Cell lymphoma (PTCL)

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

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

2. Does the prescriber agree to monitor for serious toxicities including infections, diarrhea or colitis, cutaneous reactions, and pneumonitis? ❑Yes ❑No

3. Will the patient receive prophylaxis for *Pneumocystis jirovecii* (PJP)? ❑Yes ❑No