BlueCross BlueShield Federal Employee Program

DATROWAY
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					

Datroway

(datopotamab deruxtecan-dlnk)

****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 24 vials every 84 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ vials every 84 days

2. Does the patient have a diagnosis of unresectable or metastatic breast cancer? ❑Yes ❑No

3. 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(s):
   a. Does the patient have a diagnosis of HR-positive HER2-negative (IHC 0, IHC 1+, or IHC 2+/ISH-) breast cancer? ❑Yes ❑No
   b. Has the patient received endocrine-based therapy and chemotherapy? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   a. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑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 Datroway and for 7 months 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 Datroway and for 4 months after the last dose? ❑Yes ❑No