BlueCross BlueShield Federal Employee Program

ETCAMAH
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					

Etcamah (camizestrant)

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

2. **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 Etcamah and for 1 week after the last dose? ❑Yes ❑No

3. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to use effective contraception during treatment with Etcamah and for 4 weeks after the last dose? ❑Yes ❑No

4. Will this medication be used in combination with a CDK4/6 inhibitor such as Ibrance (palbociclib), Kisqali (ribociclib), or Verzenio (abemaciclib)? ❑Yes ❑No

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

   ❑**NO** - this is **INITIATION** of therapy, please answer the following questions:
   a. Does the patient have a diagnosis of locally advanced or metastatic breast cancer? ❑Yes ❑No
   b. Does the prescriber agree to monitor electrocardiograms (ECGs) prior to initiation, weekly for the first 2 weeks of treatment, and as clinically indicated during treatment? ❑Yes ❑No
   c. Is the patient hormone receptor (HR) positive? ❑Yes ❑No
   d. Is the patient human epidermal growth factor receptor 2 (HER2)-negative? ❑Yes ❑No
   e. Has the presence of an ESR1 mutation in a plasma specimen been determined using an FDA-authorized test? ❑Yes ❑No
   f. Has the patient received at least 6 months of an aromatase inhibitor and CDK4/6 inhibitor therapy? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   a. Does the patient have a diagnosis of advanced or metastatic breast cancer? ❑Yes ❑No
   b. Does the prescriber agree to monitor electrocardiograms (ECGs) as clinically indicated? ❑Yes ❑No
   c. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Etcamah – FEP MD Fax Form Revised 11/20/2026