BlueCross BlueShield Federal Employee Program

GILOTRIF
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					

Gilotrif (afatinib)

NOTE: Form must be completed in its **entirety** for processing

Please select strength: ❑ **20mg** ❑ **30mg** ❑ **40mg**

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑ Brand ❑ Generic

How many tablets per 90 days are being requested? _____ tablet(s) per 90 days

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

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑ Advanced, recurrent or persistent head and neck cancers

i. Will Gilotrif be used as a single agent? ❑Yes ❑No

ii. Is Gilotrif being used to treat nasopharyngeal cancer? ❑Yes ❑No

iii. Has the patient's condition progressed on or after platinum containing chemotherapy? ❑Yes ❑No

❑ Metastatic Non-Small Cell Lung Cancer (NSCLC)

i. Has the patient had a confirmed non-resistant epidermal growth factor receptor (EGFR) mutations detected by an FDA-approved test? ❑Yes ❑No

❑ Metastatic squamous non-small cell lung cancer

i. Has the patient had a confirmed non-resistant epidermal growth factor receptor (EGFR) mutations detected by an FDA-approved test? ❑Yes ❑No

ii. Has the patient condition progressed after platinum-based chemotherapy? ❑Yes ❑No

❑ Recurrent brain metastases

i. Will Gilotrif be used as a single agent? ❑Yes ❑No

ii. Has the patient had an FDA approved test confirming non-resistant epidermal growth factor receptor (EGFR) mutations? ❑Yes ❑No

❑ 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?

❑ Advanced, recurrent or persistent head and neck cancers

❑ Metastatic Non-Small Cell Lung Cancer (NSCLC)

❑ Metastatic squamous non-small cell lung cancer

❑ Recurrent brain metastases

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

b. Has the patient developed life-threatening bullous, blistering, or exfoliating lesions? ❑Yes ❑No

c. Does the patient have a confirmed diagnosis of interstitial lung disease (ILD)? ❑Yes ❑No

d. Does the patient have severe hepatic impairment? ❑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.***