BlueCross BlueShield Federal Employee Program

GOMEKLI
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					

Gomekli (mirdametinib)

****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 8 milligrams per day? ❑Yes* ❑No

If YES, please specify the requested milligrams per day: _____ mg per day

1. Does the patient have a diagnosis of neurofibromatosis type 1 (NF1)? ❑Yes ❑No

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 Gomekli and for 3 months 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 Gomekli and for 6 weeks after the last dose? ❑Yes ❑No

4. 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 questions:
   a. Has a baseline ophthalmic assessment been done? ❑Yes* ❑No
      If YES, does the prescriber agree to monitor for ocular toxicities? ❑Yes ❑No
   b. Has the patient's baseline left ventricular ejection fraction (LVEF) been assessed? ❑Yes* ❑No
      If YES, does the prescriber agree to monitor the patient's LVEF? ❑Yes ❑No
   c. Is the patient symptomatic? ❑Yes ❑No
   d. Does the patient have plexiform neurofibromas (PN) that are not amenable to complete resection? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   a. Has the patient experienced any disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No
   b. Does the prescriber agree to monitor for ocular toxicities? ❑Yes ❑No
   c. Does the prescriber agree to monitor the patient's left ventricular ejection fraction (LVEF)? ❑Yes ❑No