BlueCross BlueShield Federal Employee Program

HERNEXEOS
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 cardholder 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					

Hernexeos

(zongertinib)

***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 180 milligrams per day? ❑Yes* ❑No

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

1. Does the patient have a diagnosis of unresectable or metastatic non-squamous non-small cell lung cancer (NSCLC)? ❑Yes ❑No

2. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to use effective contraception during treatment with Hernexeos and for 2 weeks after the last dose? ❑Yes* ❑No

3. Does the prescriber agree to monitor for signs and symptoms of interstitial lung disease (ILD)? ❑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. Do the tumors have HER2 (ERBB2) tyrosine kinase domain activating mutations, as detected by an FDA-authorized test? ❑Yes ❑No

   b. Does the prescriber agree to monitor liver function tests including ALT, AST, and total bilirubin prior to initiation, every 2 weeks during the first 12 weeks, and then monthly thereafter as clinically indicated? ❑Yes ❑No

   c. Does the prescriber agree to assess left ventricular ejection fraction (LVEF) prior to initiation and at regular intervals during treatment as clinically indicated? ❑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

   b. Does the prescriber agree to monitor liver function tests including ALT, AST, and total bilirubin monthly as clinically indicated? ❑Yes ❑No

   c. Does the prescriber agree to assess left ventricular ejection fraction (LVEF) at regular intervals as clinically indicated? ❑Yes ❑No