BlueCross BlueShield Federal Employee Program

HYRNUO
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							

Hyrnuo (sevabertinib)

****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 40 milligrams per day? ❑Yes* ❑No
If YES, please specify the requested quantity: _____ milligrams per day.

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

2. Has the patient been on Hyrnuo 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's tumor have HER2 (ERBB2) tyrosine kinase domain activating mutations, as detected by an FDA-approved test? ❑Yes ❑No

b. Has the patient received a prior systemic therapy? ❑Yes ❑No

c. Does the prescriber agree to monitor liver function tests including ALT, AST, and total bilirubin prior to initiation, every 2 weeks during the first month, and then monthly thereafter 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

3. Does the prescriber agree to monitor for signs and symptoms of interstitial lung disease (ILD)/pneumonitis? ❑Yes ❑No

4. Does the prescriber agree to monitor patient for new or worsening eye symptoms and refer to an ophthalmologist if needed? ❑Yes ❑No

5. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
If YES, will the patient be advised to use effective contraception during treatment with Hyrnuo and for 1 week after the last dose? ❑Yes ❑No

6. **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 Hyrnuo and for 1 week after the last dose? ❑Yes ❑No