



Federal Employee Program. **IBTROZI** **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: <input type="checkbox"/> Male <input type="checkbox"/> Female		Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:		State:	Zip:	City:		State: Zip:
Patient ID: R <input type="text"/>				Physician Signature:		
PHYSICIAN COMPLETES						

IbTROZI (taletrectinib)

****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 600 milligrams per day? ☐Yes* ☐No

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

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

3. Does the prescriber agree to monitor the patient's uric acid level and liver function tests (LFTs) including bilirubin? ☐Yes ☐No

4. **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 IbTROZI and for 3 weeks after the last dose? ☐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 IbTROZI and for 3 weeks after the last dose? ☐Yes ☐No

6. 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. Is the tumor positive for an ROS-1 mutation? ☐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