BlueCross BlueShield

IMFINZI 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

Federal Employee Program. **PRIOR APPROVAL REQUEST** 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:	NPI:				
Date of Birth: Sex: DMa		le D Female	Office Phone:	Office	Fax:				
Street Address:			Office Street Address:						
City:	State:	Zip:	City:	State:	Zip:				
Patient ID: R			Physician Signature:						
PHYSICIAN COMPLETES									

Imfinzi (durvalumab)

*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

- Has the patient been on Imfinzi continuously for the last 6 months, <u>excluding</u> samples? *Please select answer below:* **YES** this is a PA renewal for CONTINUATION of therapy, please answer the questions on <u>PAGE 3</u>
 NO this is **INITIATION** of therapy, please answer the questions below:
- 2. Is this request for brand or generic? □Brand □Generic
- 3. Does the prescriber agree to monitor for immune-mediated toxicities? □Yes □No
- 4. What is the patient's diagnosis?
 - □ Biliary tract cancer (BTC)
 - a. Does the patient have a diagnosis of locally advanced or metastatic biliary tract cancer (BTC)? TYes ONO
 - b. Will Imfinzi be used in combination with gemcitabine and cisplatin followed by Imfinzi as a single agent? Use No
 - Endometrial cancer
 - a. Does the patient have a diagnosis of primary advanced or recurrent endometrial cancer? Yes No
 - b. Is the patient's tumor status mismatch repair deficient (dMMR) as determined by an FDA-approved test? **U**Yes **U**No
 - c. Will Imfinzi be used in combination with carboplatin and paclitaxel followed by Imfinzi as a single agent? \Box Yes \Box No
 - Hepatocellular carcinoma (uHCC)
 - a. Does the patient have a diagnosis of unresectable hepatocellular carcinoma (uHCC)? UYes No
 - b. Will Imfinzi be used in combination with tremelimumab-actl followed by Imfinzi as a single agent? \Box Yes \Box No \Box Muscle invasive bladder cancer (MIBC)
 - a. Will Imfinzi be used in combination with gemcitabine and cisplatin as neoadjuvant treatment? UYes No
 - b. Will Imfinzi be used as a single agent as adjuvant treatment following radical cystectomy?

Small cell lung cancer (SCLC)

a. Does the patient have a diagnosis of limited-stage small cell lung cancer (LS-SCLC)? UYes* UNo

*If YES, please answer the following questions:

- i. Has the patient had disease progression following concurrent platinum-based chemotherapy and radiation therapy? □Yes □No
- iv. Will Imfinzi be used as a single agent? \Box Yes \Box No
- b. Does the patient have a diagnosis of extensive-stage small cell lung cancer (ES-SCLC)? UYes* UNo
 - **If YES*, will Imfinzi be used in combination with etoposide and either carboplatin or cisplatin as first-line treatment followed by Imfinzi as a single agent? □Yes □No

PLEASE PROCEED TO $\underline{PAGE\ 2}$ FOR ADDITIONAL DIAGNOSES

PAGE 1 of 3



IMFINZI

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PAGE 2 - PHYSICIAN COMPLETES

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Patient Name: _

DOB: _

Patient ID: R

□ Non-small cell lung cancer (NSCLC)

a. Does the patient have resectable, unresectable, or metastatic non-small cell lung cancer (NSCLC)? □Yes* □No **IF YES, please select answer below:*

Resectable: Please answer the following questions:

i. Does the patient have known EGFR mutations or ALK rearrangements? Yes No

ii. Is the patient's tumors greater than or equal to 4 centimeters and/or node positive? Yes No

iii. Will Imfinzi be used in combination with platinum-containing chemotherapy as neoadjuvant treatment? DYes DNo

iv. Will Imfinzi be used as a single agent as adjuvant treatment after surgery? UYes No

Unresectable: Please answer the following questions:

- i. Does the patient have unresectable stage III non-small cell lung cancer (NSCLC)? Yes No
- ii. Has the patient had disease progression following concurrent platinum-based chemotherapy and radiation therapy? □Yes □No

iv. Will Imfinzi be used as a single agent? Yes No

Metastatic: Please answer the following questions:

- i. Does the patient have sensitizing EGFR or ALK genomic tumor aberrations? UYes No
- ii. Will Imfinzi be used in combination with tremelimumab-actl and platinum-based chemotherapy? □Yes □No

Other diagnosis (*please specify*):

PAGE 2 of 3

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Imfinzi – FEP MD Fax Form Revised 5/16/2025



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Patient Information (required)				Provider Information (required)						
Date:				Provider Name:						
Patient Name:			Specialty:		NPI:					
Date of Birth:		Sex: Dale Demale		Office Phone:		Office Fax:				
Street Address:				Office Street Address:						
City:		State:	Zip:	City:	Stat	te:	Zip:			
Patient ID: R	1 1	<u> </u>		Physician Signature:			1			

PHYSICIAN COMPLETES

CONTINUATION OF THERAPY (PA RENEWAL)

Imfinzi (durvalumab)

**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

- Has the patient been on Imfinzi continuously for the last 6 months, excluding samples? *Please select answer below:* □ NO this is INITIATION of therapy, please answer the questions on <u>PAGE 1</u>
- **YES** this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
- 2. Is this request for brand or generic? Brand Generic
- 3. Has the patient experienced disease progression or unacceptable toxicity while on Imfinzi? Yes No
- 4. What is the patient's diagnosis?
 - Biliary tract cancer (BTC)
 - a. Does the patient have a diagnosis of locally advanced or metastatic biliary tract cancer (BTC)? \Box Yes \Box No
 - b. Will Imfinzi be used as a single agent? \Box Yes \Box No
 - DEndometrial cancer
 - a. Does the patient have a diagnosis of primary advanced or recurrent endometrial cancer? **U**Yes **U**No
 - b. Will Imfinzi be used as a single agent? **\Box** Yes **\Box** No
 - Hepatocellular carcinoma (uHCC)
 - a. Does the patient have a diagnosis of unresectable hepatocellular carcinoma (uHCC)? UYes No
 - b. Will Imfinzi be used as a single agent? **U**Yes **U**No
 - □Muscle invasive bladder cancer (MIBC)
 - □Non-Small cell lung cancer (NSCLC)
 - a. Does the patient have resectable, unresectable, or metastatic non-small cell lung cancer (NSCLC)? \u2224Yes* \u2224No **IF YES, please select answer below:*
 - **Resectable**: Please answer the following questions:
 - i. Is the patient post resection? \Box Yes \Box No
 - ii. Will Imfinzi be used as a single agent? □Yes □No
 - Unresectable

□**Metastatic**: Will Imfinzi be used in combination with platinum-based chemotherapy? □Yes □No

□ Small cell lung cancer (SCLC)

- a. Does the patient have a diagnosis of limited-stage small cell lung cancer (LS-SCLC)? □Yes* □No **If YES*, will Imfinzi be used as a single agent? □Yes □No
- b. Does the patient have a diagnosis of extensive-stage small cell lung cancer (ES-SCLC)? UYes* UNo
 - **If YES*, will Imfinzi be used as a single agent? \Box Yes \Box No

□ Other diagnosis (*please specify*): _