



**BlueCross
BlueShield**

Federal Employee Program

IRESSA

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						

Iressa (gefitinib)

*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

How many tablets does the patient need for 90 days? _____ tablet(s) per 90 days

1. What is the patient's diagnosis?

☐ Metastatic non-small cell lung cancer

☐ Other (*please specify*): _____

2. Does the physician agree to withhold or discontinue therapy if the patient develops grade 2 or higher ALT and/or AST elevations? ☐ Yes ☐ No

3. Does the physician agree to withhold or discontinue therapy if the patient develops worsening signs of respiratory symptoms? ☐ 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 epidermal growth factor receptor (EGFR) exon 19 deletions OR exon 21 (L858R) substitution mutations as detected by an FDA-approved test? ☐ Yes ☐ No

b. Does the patient have a confirmed diagnosis of interstitial lung disease (ILD)? ☐ Yes ☐ No

c. Does the patient have severe hepatic impairment (Child-Pugh Class C)? ☐ Yes ☐ No

d. Does the physician agree to withhold or discontinue therapy if the patient develops persistent ulcerative keratitis of the eye? ☐ Yes ☐ No

e. Does the physician agree to withhold or discontinue therapy if the patient develops a gastrointestinal perforation? ☐ 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. Has the patient developed confirmed interstitial lung disease (ILD)? ☐ Yes ☐ No

c. Has the patient developed severe hepatic impairment (Child-Pugh Class C)? ☐ Yes ☐ No

d. Has the patient developed a gastrointestinal perforation? ☐ Yes ☐ No

e. Has the patient developed persistent ulcerative keratitis of the eye? ☐ Yes ☐ No



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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST	Now you can get responses to drug Prior Authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA .
Phone (4-5 minutes for response)	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 days for response)	Fax the attached form to (877)-378-4727 . Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u>

**faster...
easier...
better...**

Introducing ePA! Online Prior Authorizations in minutes through **Caremark.com/ePA**. Sign up today!

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