BlueCross BlueShield
Federal Employee Program

# ITOVEBI
# 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** | | | | | |

## Itovebi (inavolisib)

**NOTE**: Form must be completed in its **entirety** for processing

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Will the patient need more than 9 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 breast cancer? ❑Yes ❑No
3. **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 Itovebi and for 1 week after the last dose? ❑Yes ❑No
4. **FEMALE Patient:** Is the patient of reproductive potential? ❑Yes* ❑No
   ***If YES***, will the patient be advised to use effective non-hormonal contraception during treatment with Itovebi and for 1 week after the last dose? ❑Yes ❑No
5. Will this medication be used in combination with palbociclib (Ibrance) and fulvestrant (Faslodex)? ❑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 breast cancer hormone receptor (HR) positive? ❑Yes ❑No
   b. Is the breast cancer human epidermal growth factor receptor 2 (HER2)-negative? ❑Yes ❑No
   c. Is the breast cancer PIK3CA-mutated as detected by an FDA-approved test? ❑Yes ❑No
   d. Is treatment with Itovebi following recurrence on or after completing adjuvant endocrine therapy? ❑Yes ❑No

   ❑**YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No