



Federal Employee Program.

**IWILFIN  
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:		
<b>PHYSICIAN COMPLETES</b>						

**Iwilfin (eflornithine)**

**\*\*Check [www.fepblue.org/formulary](http://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 1,536 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 high-risk neuroblastoma (HRNB)? ☐ 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 Iwilfin 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 contraception during treatment with Iwilfin and for 1 week after the last dose? ☐ Yes ☐ No

5. Is this request for **INITIATION** or **CONTINUATION** of therapy? **Please select answer below:**

☐ **INITIATION** of therapy, please answer the following questions:

a. Has the patient demonstrated at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy? ☐ Yes ☐ No

b. Does the prescriber agree to perform complete blood count (CBC), liver function tests (LFTs), and a baseline audiogram before initiating and during therapy with Iwilfin? ☐ Yes ☐ No

☐ **CONTINUATION (PA renewal)** 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 perform complete blood count (CBC), liver function tests (LFTs), and an audiogram during therapy with Iwilfin? ☐ Yes ☐ No



Federal Employee Program.

IWILFIN

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

Message:

Attached is a Prior Authorization request form.

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

<b>Electronically Online</b> (ePA) <b>Results in 2-3 minutes</b> <b>FASTEST AND EASIEST</b>	Now you can get responses to drug Prior Authorization requests <b>securely</b> online. <b>Online</b> submissions may receive <b>instant</b> 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 <b>Caremark.com/ePA.</b>
<b>Phone</b> (4-5 minutes for response)	The FEP Clinical Call Center can be reached at <b>(877)-727-3784</b> 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.
<b>Fax</b> (3-5 days for response)	Fax the attached form to <b>(877)-378-4727</b> . 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. <b><u>Please only fax the completed form once as duplicate submissions may delay processing times.</u></b>

<b>faster...</b>	Introducing ePA! Online Prior Authorizations in minutes through Caremark.com/ePA. Sign up today!
<b>easier...</b>	
<b>better...</b>	
<b>CVS/caremark</b> 	