BlueCross BlueShield Federal Employee Program

KADCYLA
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					

Kadcyla (ado-trastuzumab)

****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. Has the patient been on Kadcyla continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑HER2-positive early breast cancer

i. Does the patient have residual invasive disease following neoadjuvant taxane and trastuzumab (Herceptin)-based treatment? ❑Yes ❑No

❑HER2-positive metastatic breast cancer

i. Has the patient received prior therapy with trastuzumab (Herceptin) alone or trastuzumab (Herceptin) with a taxane? ❑Yes ❑No*****

****If NO***, has the patient developed disease recurrence during or within six months of completing adjuvant therapy? ❑Yes ❑No

❑Other diagnosis, ***(please specify):*** _____

b. Will the patient's hepatic function and platelet counts be monitored prior to initiation and prior to receiving each dose? ❑Yes ❑No

c. Will the patient's left ventricular ejection fraction (LVEF) be monitored prior to initiation and every three months or more frequently as clinically indicated during treatment? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑HER2-positive breast cancer

❑Other diagnosis, ***(please specify):*** _____

b. Has the patient been diagnosed with nodular regenerative hyperplasia (NRH)? ❑Yes ❑No

c. Will the patient's hepatic function and platelet count be monitored prior to receiving each dose? ❑Yes ❑No

d. Will the patient's left ventricular ejection fraction (LVEF) be monitored every three months or more frequently as clinically indicated during treatment? ❑Yes ❑No

2. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No

****If YES***, will the patient be advised to use effective contraception during treatment with Kadcyla and for seven months after the last dose? ❑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 Kadcyla and for four months after the last dose? ❑Yes ❑No

4. Does the prescriber agree to monitor for pulmonary toxicity? ❑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. ***Please only fax the completed form once as duplicate submissions may delay processing times.***