BlueCross BlueShield
Federal Employee Program

KOMZIFTI
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								

Komzifti (ziftomenib)

****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

Will the patient need more than 600 milligrams per day? ❑Yes* ❑No
If YES, please specify the requested quantity: _____ milligrams per day.

1. Does the patient have a diagnosis of relapsed or refractory acute myeloid leukemia (AML)? ❑Yes ❑No
2. Has the patient been on Komzifti continuously for the last **6 months** excluding samples?

❑**NO** – this is **INITIATION** of therapy, please answer the following question:
- a. Does the patient have susceptible nucleophosmin 1 (NPM1) mutation? ❑Yes ❑No
- b. Does the patient have satisfactory alternative treatment options? ❑Yes ❑No
- c. Does the prescriber agree to correct electrolyte abnormalities, including hypokalemia and hypomagnesemia, prior to treatment? ❑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?

3. Does the prescriber agree to monitor for signs and symptoms of differentiation syndrome?
4. Does the prescriber agree to monitor for QTc interval prolongation?
5. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to use effective contraception during treatment with Komzifti and for 6 months after the last dose? ❑Yes ❑No
6. **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 Komzifti and for 3 months after the last dose? ❑Yes ❑No

