



Federal Employee Program. **KRAZATI**  
**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: <b>R</b>				Physician Signature:		
<b>PHYSICIAN COMPLETES</b>						

**Krazati (adagrasib)**

\*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 1,200 milligrams per day? ☐ Yes\* ☐ No

\*If YES, please specify the requested milligrams per day: \_\_\_\_\_ mg per day

2. Does the prescriber agree to monitor the patient's AST, ALT, alkaline phosphatase, and total bilirubin levels? ☐ Yes ☐ No

3. Does the prescriber agree to monitor for QTc prolongation as clinically indicated? ☐ Yes ☐ No

4. Has the patient been on Krazati 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 there a presence of the KRAS G12C mutation as determined by an FDA-approved test? ☐ Yes ☐ No

b. What is the patient's diagnosis? *Please select answer below:*

☐ Locally advanced or metastatic non-small cell lung cancer (NSCLC)

i. Will this medication be used a single agent? ☐ Yes ☐ No

ii. Has the patient received at least one prior systemic therapy? ☐ Yes ☐ No

☐ Locally advanced or metastatic colorectal cancer (CRC)

i. Will this medication be used in combination with \*Erbix (cetuximab)? ☐ Yes ☐ No

\*Erbix (cetuximab) requires prior-authorization.

ii. Has the patient received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy? ☐ Yes ☐ No

☐ Other diagnosis (*please specify*): \_\_\_\_\_

☐ **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 Krazati? ☐ Yes ☐ No

b. What is the patient's diagnosis? *Please select answer below:*

☐ Locally advanced or metastatic non-small cell lung cancer (NSCLC)

i. Will this medication be used a single agent? ☐ Yes ☐ No

☐ Locally advanced or metastatic colorectal cancer (CRC)

i. Will this medication be used in combination with \*Erbix (cetuximab)? ☐ Yes ☐ No

\*Erbix (cetuximab) requires prior-authorization.

☐ Other diagnosis (*please specify*): \_\_\_\_\_



**BlueCross  
BlueShield**

Federal Employee Program

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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:

<b>Electronically Online (ePA)</b> <b>Results in 2-3 minutes 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> <b>(4-5 minutes for response)</b>	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> <b>(3-5 days for response)</b>	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... easier... better...</b>	Introducing ePA! Online Prior Authorizations in minutes through <b>Caremark.com/ePA</b> . Sign up today!
	<b>CVS/caremark</b> 