BlueCross BlueShield
Federal Employee Program

LAZCLUZE
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					

Lazcluze (lazertinib)

****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. Will the patient need more than 240 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 non-small cell lung cancer (NSCLC)? ❑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 Lazcluze and for 3 weeks 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 Lazcluze and for 3 weeks after the last dose? ❑Yes ❑No
5. 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. Does the prescriber agree to administer anticoagulant prophylaxis to prevent venous thromboembolic events (VTE) for at least the first four months of treatment? ❑Yes ❑No
   - b. Does the patient have EGFR exon 19 deletions or exon 21 L858R substitution mutations, as detected by an FDA-approved test? ❑Yes ❑No
   - c. Will this medication be used as first-line treatment in combination with Rybrevant (amivantamab)? ❑Yes ❑No

   ❑**YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   - a. Does the prescriber agree to monitor for signs and symptoms of venous thromboembolic events (VTE)? ❑Yes ❑No
   - b. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No