BlueCross BlueShield Federal Employee Program®

LUMAKRAS
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					

Lumakras (sotorasib)

***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 960 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. What is the patient's diagnosis?
   ❑Locally advanced or metastatic non-small cell lung cancer (NSCLC)
   a. 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:
   i. Is there a presence of the *KRAS G12C* mutation as determined by an FDA-approved test? ❑Yes ❑No
   ii. Has the patient received at least one prior systemic therapy? ❑Yes ❑No
   iii. Will this medication be used as a single agent? ❑Yes ❑No
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   i. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No

   ❑Metastatic colorectal cancer (mCRC)
   a. 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:
   i. Is there a presence of the *KRAS G12C* mutation as determined by an FDA-approved test? ❑Yes ❑No
   ii. Has the patient received prior fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy? ❑Yes ❑No
   iii. Will this medication be used in combination with Vectibix (panitumumab)? ❑Yes ❑No
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   i. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No

   ❑None of the above