

Federal Employee Program.

## **LYNPARZA**

PRIOR APPROVAL REQUEST 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. 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

Patient Information (required)  Date:		Provider Information (required) 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:	City: State: Zip:	
Patient ID:		Physician Signature:		
PHYSICIAN COMPLETES				
_				
Lynparza (olaparib)  **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 G		Zoo* □No		
1. Will the patient need more than 360 tablets every 90 days? □Yes* □No  *If YES, please specify the requested quantity: tablets every 90 days				
2. What is the patient's diagnosis?	•	adolets every 70 days		
□Advanced epithelial ovarian cancer <b>OR</b> □	Advanced fallo	ppian tube cancer OR $\Box$	Advanced primary peritoneal cancer	
a. Has the patient been on this medication co		· —		
□ NO – this is <b>INITIATION</b> of therapy,	please answer	the following questions:	-	
i. Does the patient have a BRCA-posit	tive mutation?	□Yes □No*		
*If NO, please answer the following questions:				
1) Will Lynparza be used in co				
2) Is the patient's cancer associate				
		_	ncy (HRD) positive status? □Yes* □N	
*If YES, is the homologo	us recombination	on deficiency (HRD) positiv	ve status defined by deleterious or	
*If YES, is the homologous suspected deleterious BRG	ous recombination or CA mutation or	on deficiency (HRD) positive genomic instability? \(\square\)Ye	ve status defined by deleterious or s* (If YES, select answer below)	
*If YES, is the homologor suspected deleterious BRO  □Deleterious or suspe	ous recombination or ected deleteriou	on deficiency (HRD) positive genomic instability?    Ye s BRCA mutation    OR	ve status defined by deleterious or s* ( <i>If YES</i> , <i>select answer below</i> )   No   \q	
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PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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BlueShield. LYNPARZA
Federal Employee Program. PRIOR APPROVAL REQUEST

Federal Employee Program. PRIOR APPROVAL REQUES!

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.

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PAGE 2 - PHYSICIAN COMPLETES			
Patient Name:	DOB:	Patient ID: R	
☐ Metastatic breast cancer			
a. Has the patient been on this	medication continuously for th	e last 6 months excluding samples? Please select answer below:	
$\square$ <b>NO</b> – this is <b>INITIATIO</b>	N of therapy, please answer the	e following questions:	
i. Does the patient have	a BRCA-positive mutation?	lYes □No	
ii. Is the metastatic brea	ast cancer HER2-negative?	es □No	
iii. Did the patient have	prior chemotherapy in the neoa	adjuvant, adjuvant, or metastatic setting? □Yes □No	
iv. Is the metastatic brea	ast cancer HR-positive? □Yes	□No	
v. Has the patient been	treated previously with endocri	ne therapy? □Yes □No*	
*If NO, is the patie	ent considered an inappropriate	candidate for endocrine therapy? □Yes □No	
☐ <b>YES</b> – this is a PA renew	al for CONTINUATION of th	erapy, please answer the following question:	
i. Has the patient experie	enced disease progression or un	acceptable toxicity while on the requested therapy? □Yes □No	
☐ Metastatic castration-resistant pr	rostate cancer (mCRPC)		
a. Has the patient been on this	medication continuously for th	e last 6 months excluding samples? Please select answer below:	
	N of therapy, please answer the	• •	
_	a BRCA-positive mutation? <b>P</b>	lease select answer below:	
	r the following questions:		
		n abiraterone (Zytiga)? □Yes □No	
• •		n prednisone or prednisolone? □Yes □No	
	tient's disease progressed follov ■Yes □No	ving prior treatment with enzalutamide or abiraterone	
□ <b>No</b> : Please answer	the following questions:		
1) Does the pa	atient have a homologous recon	nbination repair (HRR) gene mutation? □Yes □No	
2) Has the pat (Zytiga)? □		ving prior treatment with enzalutamide or abiraterone	
ii. Has the patient had a	a bilateral orchiectomy? □Yes	□No*	
*If NO, will the pa	tient be receiving a gonadotrop	in-releasing hormone (GnRH) analog concurrently? □Yes □No	
		erapy, please answer the following question:	
i. Has the patient experi	ienced disease progression or un	nacceptable toxicity while on the requested therapy? □Yes □No	
☐ Metastatic pancreatic cancer			
-	•	e last 6 months excluding samples? Please select answer below:	
	N of therapy, please answer the	• •	
_	a BRCA-positive mutation?		
•	• •	ks of a first-line platinum-based chemotherapy regimen? □Yes □No	
		erapy, please answer the following question:	
• •	• •	nacceptable toxicity while on the requested therapy? □Yes □No	
<b>U</b> Other ( <i>please specify</i> ):			

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