BlueCross BlueShield 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)			**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					

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 ❑Generic

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?

❑Advanced epithelial ovarian cancer **OR** ❑Advanced fallopian tube cancer **OR** ❑Advanced primary peritoneal cancer

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. Does the patient have a BRCA-positive mutation? ❑Yes ❑No*****

If NO, please answer the following questions:

1) Will Lynparza be used in combination with bevacizumab (Avastin)? ❑Yes ❑No

2) Is the patient's cancer associated with homologous recombination deficiency (HRD) positive status? ❑Yes***** ❑No

If YES, is the homologous recombination deficiency (HRD) positive status defined by deleterious or suspected deleterious BRCA mutation or genomic instability? ❑Yes***** ***(If YES, select answer below)*** ❑No

❑Deleterious or suspected deleterious BRCA mutation **OR** ❑Genomic instability

ii. Has the patient had a complete or partial response to platinum-based chemotherapy? ❑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

❑Recurrent epithelial ovarian cancer **OR** ❑Recurrent fallopian tube cancer **OR** ❑Recurrent primary peritoneal cancer

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. Does the patient have a BRCA-positive mutation? ❑Yes ❑No

ii. Has the patient had a complete or partial response to platinum-based chemotherapy? ❑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

❑Early breast cancer

a. Is the patient high risk? ❑Yes ❑No

b. Does the patient have a BRCA-positive mutation? ❑Yes ❑No

c. Is the breast cancer HER2-negative? ❑Yes ❑No

d. Has the patient been previously treated with neoadjuvant or adjuvant chemotherapy? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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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 the last **6 months** excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have a BRCA-positive mutation? ❑Yes ❑No

ii. Is the metastatic breast cancer HER2-negative? ❑Yes ❑No

iii. Did the patient have prior chemotherapy in the neoadjuvant, adjuvant, or metastatic setting? ❑Yes ❑No

iv. Is the metastatic breast cancer HR-positive? ❑Yes ❑No

v. Has the patient been treated previously with endocrine therapy? ❑Yes ❑No*****

****If NO***, is the patient considered an inappropriate candidate for endocrine therapy? ❑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 castration-resistant prostate cancer (mCRPC)

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. Does the patient have a BRCA-positive mutation? ***Please select answer below:***

❑**Yes**: Please answer the following questions:

1) Will Lynparza be used in combination with abiraterone (Zytiga)? ❑Yes ❑No

2) Will Lynparza be used in combination with prednisone or prednisolone? ❑Yes ❑No

3) Has the patient's disease progressed following prior treatment with enzalutamide or abiraterone (Zytiga)? ❑Yes ❑No

❑**No**: Please answer the following questions:

1) Does the patient have a homologous recombination repair (HRR) gene mutation? ❑Yes ❑No

2) Has the patient's disease progressed following prior treatment with enzalutamide or abiraterone (Zytiga)? ❑Yes ❑No

ii. Has the patient had a bilateral orchiectomy? ❑Yes ❑No*****

****If NO***, will the patient be receiving a gonadotropin-releasing hormone (GnRH) analog concurrently? ❑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 pancreatic cancer

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. Does the patient have a BRCA-positive mutation? ❑Yes ❑No

ii. Has the patient's disease progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen? ❑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

❑ Other ***(please specify)***: _____