



BlueCross BlueShield. **MODEYSO**  
Federal Employee Program. **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:
Patient ID:		R		Physician Signature:		
<b>PHYSICIAN COMPLETES</b>						

**Modeyso (dordaviprone)**

\*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

Will the patient need more than 60 capsules every 84 days?  Yes\*  No

\*If YES, please specify the requested quantity: \_\_\_\_\_ capsules for 84 days

1. Does the patient have a diagnosis of diffuse midline glioma?  Yes  No

2. **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 Modeyso and for 1 month after the last dose?  Yes  No

3. **FEMALE Patient:** Is the patient of reproductive potential?  Yes\*  No

\*If YES, will the patient be advised to use effective contraception during treatment with Modeyso and for 1 month after the last dose?  Yes  No

4. 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 tumor carry a H3 K27M mutation?  Yes  No

b. Does the patient have progressive disease following prior therapy?  Yes  No

**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 the requested therapy?  Yes  No