

physician portion and submit this completed form

Federal Employee Program.

OJEMDA 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

Patient Information (required)			Provider Information (required)			
Date:			Provider Name:			
Patient Name:			Specialty:	NPI:	NPI:	
Date of Birth:	Sex: DMale	Gemale	nale Office Phone: Office Fax:			
Street Address:			Office Street Address:			
City:	State:	Zip:	City:	State:	Zip:	
Patient ID:			Physician Signature:			
PHYSICIAN COMPLETES						

Ojemda (tovorafenib)

NOTE: Form must be completed in its entirety for processing

Please select strength and provide quantity:

□100 mg tablet	Will the patient need more than 72 tablets every 84 days? □Yes* □No		
	*If YES, please specify the requested quantity: tablets every 84 days		
□25 mg/mL oral suspension	Will the patient need more than 24 bottles every 84 days? □Yes* □No		
	*If YES, please specify the requested quantity: bottles every 84 days		

**Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

Is this request for brand or generic? \Box Brand \Box Generic

- 1. Does the patient have a diagnosis of relapsed or refractory pediatric low-grade glioma (LGG)? Yes No
- 2. 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 question:
 - a. Has the patient had a BRAF fusion or rearrangement? Yes No
 - b. Does the patient have a BRAF V600 mutation? Yes No
 - □ YES this is a PA renewal for CONTINUATION of therapy, please answer the following question: a. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? □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 Ojemda and for 28 days after the last dose? □Yes □No
- 4. 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 Ojemda and for 2 weeks after the last dose? \Box Yes \Box No



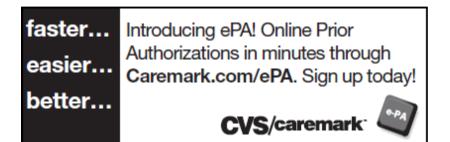
BlueShield. OJEMDA Federal Employee Program. PRIOR APPROVAL REQUEST

Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST	Now you can get responses to drug Prior Authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA.
Phone (4-5 minutes for response)	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM- 9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 days for response)	Fax the attached form to (877)-378-4727. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <u>Please only fax the completed form once as</u> <u>duplicate submissions may delay processing</u> <u>times.</u>



The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Ojemda – FEP MD Fax Form Revised 6/14/2024