BlueCross BlueShield
Federal Employee Program

PHESGO
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder 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					

Phesgo

(pertuzumab, trastuzumab, and hyaluronidase-zzxf)

****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

How many injections will the patient need every 84 days? _____ injection(s) every 84 days

1. Has the patient been on Phesgo continuously for the last **6 months**, excluding samples? ***Please select answer below:***

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

a. What is the patient's diagnosis?

❑Early Breast Cancer

i. Is Phesgo being used as neoadjuvant treatment for HER2-positive locally advanced, inflammatory, or early stage breast cancer? ***Please select answer below:***

❑**Yes**: Does the patient a tumor that is greater than 2 cm in diameter or node positive? ❑Yes ❑No

❑**No**: Is Phesgo being used as adjuvant treatment for HER2-positve early breast cancer? ❑Yes ❑No

ii. Will Phesgo be used in combination with chemotherapy? ❑Yes ❑No

❑Metastatic Breast Cancer

i. Is Phesgo being used to treat HER2-positive metastatic breast cancer? ❑Yes ❑No

ii. Will Phesgo be used in combination with docetaxel? ❑Yes ❑No

iii. Does the patient have a history of prior anti-HER2 therapy or chemotherapy for metastatic disease? ❑Yes ❑No

❑Other diagnosis ***(please specify)***:_____

b. Does the patient have an overexpression of the HER2 protein or amplification of the HER2 gene as confirmed by an FDA-approved test? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Metastatic Breast Cancer

i. Is Phesgo being used to treat HER2-positive metastatic breast cancer? ❑Yes ❑No

ii. Will Phesgo be used in combination with docetaxel? ❑Yes ❑No

❑Other diagnosis ***(please specify)***:_____

b. Does the patient have any disease progression or unacceptable toxicity? ❑Yes ❑No

2. Does the patient have a left ventricular ejection fraction (LVEF) of greater than or equal to 50%? ❑Yes ❑No
3. Does the prescriber agree to monitor cardiac function and monitor for pulmonary toxicity? ❑Yes ❑No
4. Will Phesgo be used intravenously? ❑Yes ❑No
5. Will Phesgo be administered by a healthcare professional? ❑Yes ❑No
6. **FEMALE Patient**: Is the patient of child-bearing potential? ❑Yes* ❑No

If YES, will the patient be advised to use effective contraception during treatment with Phesgo and for seven months after the last dose? ❑Yes ❑No

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. Phesgo – FEP MD Fax Form Revised 8/21/2020

BlueCross BlueShield
Federal Employee Program

PHESGO
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

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. ***Please only fax the completed form once as duplicate submissions may delay processing times.***