BlueCross BlueShield
Federal Employee Program.

PIQRAY
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: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Piqray (alpelisib)

NOTE: Form must be completed in its **entirety** for processing

Which daily dose is being requested? ***Please select daily dose below:***

❑ **200mg daily dose pack (one 200mg tablet daily)**
❑ **300mg daily dose pack (two 150mg tablets daily)**
❑ **250mg daily dose pack (one 200mg tablet and one 50mg tablet daily)**
❑ **Multiple dose packs** ***(specify combination and directions)***: _____

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

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of advanced or metastatic breast cancer? ❑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 condoms and effective contraception during treatment with Piqray and for 1 week 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 Piqray and for 1 week after the last dose? ❑Yes ❑No
4. Does the prescriber agree to monitor for severe cutaneous reactions, such as Stevens-Johnson syndrome (SJS) or drug reaction with eosinophilia and systemic symptoms (DRESS)? ❑Yes ❑No
5. Does the prescriber agree to monitor for pneumonitis? ❑Yes ❑No
6. Does the prescriber agree to monitor for elevated glucose and decrease the dose or discontinue therapy as required? ❑Yes ❑No
7. Will Piqray be used in combination with fulvestrant (Faslodex)? ❑Yes ❑No
8. 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. Is the breast cancer hormone receptor (HR) positive? ❑Yes ❑No
   b. Is the breast cancer human epidermal growth factor receptor 2 (HER2)-negative? ❑Yes ❑No
   c. Is the breast cancer PIK3CA-mutated as detected by an FDA-approved test? ❑Yes ❑No
   d. Has the patient had disease progression on or after an endocrine-based regimen? ❑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

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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.***