BlueCross BlueShield
Federal Employee Program

RETEVMO
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					

Retevmo (selpercatinib)

****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

Will the patient need more than 320 milligrams per day? ❑Yes* ❑No

If YES, please specify the requested milligrams per day: _____ mg per day

1. Has the patient been on Retevmo 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?

❑Locally advanced non-small cell lung cancer (NSCLC) **OR** ❑Metastatic non-small cell lung cancer (NSCLC)

i. Is the patient's diagnosis RET fusion-positive, as detected by an FDA-approved test? ❑Yes ❑No

❑Advanced medullary thyroid cancer (MTC) **OR** ❑Metastatic medullary thyroid cancer (MTC)

i. Does the patient have RET-positive mutation, as detected by an FDA-approved test? ❑Yes ❑No

ii. Does the patient require systemic therapy? ❑Yes ❑No

❑Advanced thyroid cancer **OR** ❑Metastatic thyroid cancer

i. Is the patient's diagnosis RET fusion-positive, as detected by an FDA-approved test? ❑Yes ❑No

ii. Is the patient radioactive iodine-refractory, if radioactive iodine is appropriate? ***Please select answer below:***

❑Yes ❑No ❑Radioactive iodine is not appropriate

iii. Does the patient require systemic therapy? ❑Yes ❑No

❑Locally advanced solid tumors **OR** ❑Metastatic solid tumors

i. Is the patient's diagnosis RET fusion-positive, as detected by an FDA-approved test? ❑Yes ❑No

ii. Has the patient's disease progressed on or following prior systemic treatment? ❑Yes ❑No*

If NO, does the patient have satisfactory alternative treatment options? ❑Yes ❑No

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

b. Will any pre-existing hypocalcemia, hypokalemia, or hypomagnesemia be corrected prior to staring Retevmo? ❑Yes ❑No

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

a. What is the patient's diagnosis?

❑Locally advanced non-small cell lung cancer (NSCLC) **OR** ❑Metastatic non-small cell lung cancer (NSCLC)

❑Advanced medullary thyroid cancer (MTC) **OR** ❑metastatic medullary thyroid cancer (MTC)

❑Advanced thyroid cancer **OR** ❑Metastatic thyroid cancer

❑Locally advanced solid tumors **OR** ❑Metastatic solid tumors

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

b. Has the patient experienced disease progression or unacceptable toxicity while on Retevmo? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

2. Does the prescriber agree to monitor AST, ALT, and blood pressure? ❑Yes ❑No

3. Does the prescriber agree to monitor for QT interval prolongation? ❑Yes ❑No

4. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No
   ****If YES***, will the patient be advised to use effective contraception during treatment with Retevmo and for one week after the last dose? ❑Yes ❑No

5. **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 Retevmo and for one week after the last dose? ❑Yes ❑No

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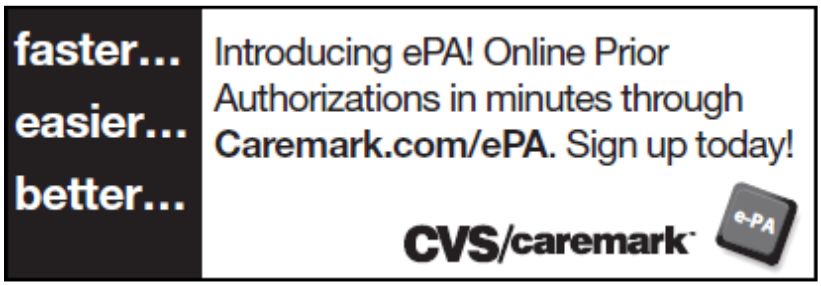
Message:

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 info 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 PA request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***



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. Retevmo – FEP MD Fax Form Revised 06/28/2024

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