BlueCross BlueShield
Federal Employee Program

ROMVIMZA
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					

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

Romvimza
(vimseltinib)

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

1. Does the patient have a diagnosis of symptomatic tenosynovial giant cell tumor (TGCT) ❑Yes ❑No*
   ***If NO,** please specify.: _____

2. Does the prescriber agree to monitor liver tests for hepatotoxicity during therapy and discontinue if necessary? ❑Yes ❑No

3. 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. Will surgical resection potentially cause worsening functional limitation or severe morbidity)? ❑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

4. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No
   ***If YES**, will the patient be advised to use effective contraception during treatment and for 1 month after the last dose?
   ❑Yes ❑No

5. Will the patient need more than 24 capsules every 84 days? ❑Yes* ❑No
   **** If YES,** please specify requested quantity: _____ capsules every 84 days