

BlueShield. SARCLISA
Federal Employee Program. 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

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.

Attn. Clinical Services
Fax: 1-877-378-4727

Patient Name: Specialty: Specialty: NPI:	Patient Information (required)					Provider Information (required)			
Date of Birth: Sex: Maile Demale Office Phone: Office Fax: Street Address: Office Street Address: Zip: City: State: Zip: Zip: Patient ID: Physician Signature: Physician Signature: Physician Signature: PHYSICIAN COMPLETES SATClisa (isatuximab-irfc) **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 1. Does the patient have a diagnosis of multiple mycloma (MM)? Yes* JNO **If YES, has the patient been on Sarclisa continuously for the last 6 months, excluding samples? Please select answer below: JNO This is INITIATION of therapy, please answer the following questions: a. Is the multiple mycloma newly diagnosed? Please select answer below: JYES Please sanswer the following questions: i. Is the patient eligible for autologous stem cell transplant (ASCT)? Yes JNO ii. Will this medication be used in combination with bortezomib (Velcade)*, lenalidomide (Revlimid)*, and dexamethasone? **Velcade (bortezomib) and Revlimid (lenalidomide) require prior-authorization. JNO Will Sarclisa be used in combination with ether pomalidomide (Pomalyst) and dexamethasone or carfilzomib (Kyprolis) and dexamethasone: Please answer the following question(s): Carfilzomib (Kyprolis)* and dexamethasone: Please answer the following questions: *Kyprolis (carfilzomib) requires prior-authorization. i. Does the patient received one to three prior lines of therapy? Yes NO Pomalidomide (Pomalyst)* and dexamethasone: Please answer the following questions: a. Has the patient received one to three prior lines of therapy? Yes NO Pomalidomide (Pomalyst)* and dexamethasone: Has the patient received at least two prior therapies including a proteasoone inhibitor (P) and lenalidomide (Revlimid)* Yes NO YES - this is a PA renewal for CONTINUATION therapy, please answer the following question: a.	Date:					Provider Name:			
Street Address: Office Street Address: Zip: City: State: Zip: Zip: Physician Signature: Physician	Patient Name:					Specialty:		NPI:	
City: State: Zip: City: State: Zip: Physician Signature:	Date of Birth:		Sex: □Male □Female		Office Phone:		Office Fax:		
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