BlueCross BlueShield Federal Employee Program

# SCEMBLIX
# 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** | | | | | |

## Scemblix (asciminib)

****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. How many milligrams will the patient need per day? _____ mg per day

2. Does the patient have a diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase? ❑Yes ❑No

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

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

a. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ***(*If YES, please answer the following questions)*** ❑No

i. Will pregnancy status be verified prior to starting treatment? ❑Yes ❑No

ii. Will the patient be advised to use effective contraception during treatment with Scemblix and for one week after the last dose? ❑Yes ❑No

b. Does the patient have the T315I mutation? ❑Yes ❑No*****

****If NO***, is the patient's diagnosis of CML newly diagnosed or previously treated? ***Please select answer below:***

❑Yes, newly diagnosed ❑Yes, previously treated ❑No

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

a. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No

****If YES***, will the patient be advised to use effective contraception during treatment with Scemblix and for one week after the last dose? ❑Yes ❑No

b. Does the patient have the T315I mutation? ❑Yes ❑No