BlueCross BlueShield Federal Employee Program.

STIVARGA
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					

Stivarga (regorafenib)

****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

How many tablets of Stivarga will the patient be taking per day (4 tablets = 160mg daily)? _____ tablet(s) per day

1. Does the patient show signs or symptoms of severe hemorrhage? ❑Yes ❑No
2. Has the patient been on Stivarga 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?

❑Cholangiocarcinoma

❑Gastrointestinal Stromal Tumor (GIST)

i. Is the patient's tumor unresectable, metastatic, or locally advanced? ❑Yes ❑No

ii. Has the patient preciously been treated with both Gleevec (imatinib) and Sutent (sunitinib)? ❑Yes ❑No

❑Hepatocellular Carcinoma (HCC)

i. Has the patient been previously treated with sorafenib (Nexavar)? ❑Yes ❑No

❑Metastatic Colorectal Cancer (CRC)

i. Has the patient been previously treated with fluoropyrimidine-, oxaliplatin-and irinotecan-based chemotherapy? ❑Yes ❑No

ii. Does the patient have RAS wild-type metastatic colorectal cancer? ❑Yes***** ❑No

****If YES***, has the patient previously been treated with an anti-EGFR therapy? ❑Yes ❑No

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

b. Will the patient's ALT, AST, and bilirubin tests be assessed before initiation of therapy? ❑Yes***** ❑No

****If YES***, will the patient's ALT, AST, and bilirubin levels be monitored every two weeks during the first two months of treatment, then monitored at least monthly? ❑Yes ❑No

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

a. What is the patient's diagnosis?

❑Cholangiocarcinoma ❑Hepatocellular Carcinoma (HCC) ❑Metastatic Colorectal Cancer (CRC)

❑Gastrointestinal Stromal Tumor (GIST)

i. Is the patient's tumor unresectable, metastatic, or locally advanced? ❑Yes ❑No

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

b. Are the patient's liver function tests (LFTs) less than 3 times the upper limit of normal (ULN) or baseline? ❑Yes ❑No

c. Does the patient show signs and symptoms of gastrointestinal perforation or fistula? ❑Yes ❑No

d. Has the patient developed Reversible Posterior Leukoencephalopathy Syndrome (RPLS)? ❑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.***