BlueCross BlueShield Federal Employee Program

SUTENT
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					

For Standard and Basic Option patients GENERIC Sutent is a preferred product. Please consider prescribing the preferred product. Standard/Basic Option patients who switch to the preferred product will be eligible for 2 copays at no cost in the benefit year.

Sutent (sunitinib)

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

Please select strength and provide quantity:

❑ **12.5 mg**	**qty _____ per 84 days**	❑ **37.5 mg**	**qty _____ per 84 days**
❑ **25 mg**	**qty _____ per 84 days**	❑ **50 mg**	**qty _____ per 84 days**

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

1. Has the patient been on Sutent continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑ Brand ❑ Generic
3. **BRAND Sutent Request** (**Standard/Basic Option Patient):** Would you like to switch the patient to the preferred product, sunitinib (**GENERIC** Sutent)? ❑Yes ❑No*
   If NO,** does the patient have an intolerance or contraindication or have they had an inadequate treatment response to sunitinib (**generic** Sutent)? ***Please select answer below:
   ❑**Yes** ***(specify result)***: _____
   ❑**No**: Is there a clinical reason for not trying sunitinib (**generic** Sutent)? ❑Yes* ❑No
   If YES, please specify: _____
4. **GENERIC Sutent Request (Standard/Basic Option Patient):** Is sunitinib (**generic** Sutent) being requested as a change from **BRAND** Sutent to allow the member access to their copay benefit? ❑Yes ❑No
5. Does the prescriber agree to monitor ALT, AST, and bilirubin tests before initiation of therapy? ❑Yes* ❑No
   If YES, does the prescriber agree to monitor ALT, AST, and bilirubin tests every cycle and as clinically indicated? ❑Yes ❑No
6. What is the patient's diagnosis?
   ❑ Chordoma
      a. Is the chordoma recurrent? ❑Yes ❑No
   ❑ Follicular thyroid carcinoma
      a. Is the patient's thyroid carcinoma unresectable or metastatic? ❑Yes ❑No
   ❑ Gastrointestinal Stromal Tumor (GIST)
      a. Is the patient intolerant to or has the patient had disease progression on imatinib mesylate (Gleevec)? ❑Yes ❑No
   ❑ Hurthle cell thyroid carcinoma
      a. Is the patient's thyroid carcinoma unresectable or metastatic? ❑Yes ❑No
   ❑ Thymic carcinoma

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 – PHYSICIAN COMPLETES

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

❑ Medullary thyroid carcinoma

a. Is the patient's medullary thyroid carcinoma progressive or symptomatic distant metastatic disease? ❑Yes ❑No

❑ Neuroendocrine tumors

a. Are the patient's neuroendocrine tumors unresectable or metastatic? ❑Yes ❑No

❑ Papillary thyroid carcinoma

a. Is the patient's thyroid carcinoma unresectable or metastatic? ❑Yes ❑No

❑ Renal Cell Carcinoma (RCC)

a. Is the patient's renal cell carcinoma relapsed or unresectable? ❑Yes ❑No*

***If NO**, is Sutent being used as adjuvant treatment in a patient that is at high risk of recurrent renal cell carcinoma following a nephrectomy? ❑Yes ❑No

❑ Soft tissue sarcoma

a. Which subtype is the soft tissue sarcoma? ***Please select answer below:***

❑Alveolar Soft Part Sarcoma (ASPS) ❑Angiosarcoma ❑Hemangiopericytoma ❑Solitary fibrous tumor

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

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

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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					

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CONTINUATION OF THERAPY (PA RENEWAL)

Sutent (sunitinib)

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1. Has the patient been on Sutent continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
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   If YES, please specify: _____
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5. What is the patient's diagnosis?
   ❑Chordoma
   ❑Follicular thyroid carcinoma
   ❑Gastrointestinal Stromal Tumor (GIST)
   ❑Hurthle cell thyroid carcinoma
   ❑Medullary thyroid carcinoma
   ❑Soft tissue sarcoma
   ❑Neuroendocrine tumors
   ❑Papillary thyroid carcinoma
   ❑Renal Cell Carcinoma (RCC)
   ❑Thymic carcinoma
   a. Which subtype is the soft tissue sarcoma? ***Please select answer below:***
   ❑Alveolar Soft Part Sarcoma (ASPS) ❑Angiosarcoma ❑Hemangiopericytoma ❑Solitary fibrous tumor
   ❑Other subtype ***(please specify)***: _____
   ❑Other diagnosis ***(please specify)***: _____
6. Does the patient have severe hepatic impairment (Child-Pugh Class C)? ❑Yes ❑No
7. Has the patient experienced disease progression or unacceptable toxicity while on Sutent? ❑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 information 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 Prior Authorization 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. Sutent – FEP MD Fax Form Revised 5/5/2023