BlueCross BlueShield Federal Employee Program.

TIBSOVO
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					

Tibsovo (ivosidenib)

****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. Will the patient need more than 180 tablets every 90 days? ❑Yes***** ❑No
   If YES, please specify the requested quantity: _____ tablets per 90 days
2. Does the prescriber agree to monitor for signs and symptoms of differentiation syndrome? ❑Yes ❑No
3. Does the prescriber agree to monitor electrocardiograms (ECGs) for QTc prolongation? ❑Yes ❑No
4. Does the prescriber agree to monitor for signs and symptoms of Guillain-Barre syndrome? ❑Yes ❑No
5. What is the patient's diagnosis?

❑Acute Myeloid Leukemia (AML)

a. Does the patient have relapsed or refractory acute myeloid leukemia? ❑Yes ❑No*****

If NO, please answer the following questions:

i. Does the patient have comorbidities that preclude the use of intensive induction chemotherapy? ❑Yes ❑No

ii. Will Tibsovo be used in combination with azacitidine **OR** as monotherapy? ❑Yes***** ❑No

If YES, select one of the following: ❑In combination with azacitidine **OR** ❑Monotherapy

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

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

i. Is the acute myeloid leukemia newly diagnosed? ❑Yes ❑No

ii. Does the patient have a susceptible isocitrate dehydrogenase-1 (IDH1) mutation detected by an FDA-approved test? ❑Yes ❑No

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

i. Has the patient experienced disease progression or unacceptable toxicity while on Tibsovo? ❑Yes ❑No

❑Cholangiocarcinoma

a. Does the patient have locally advanced or metastatic cholangiocarcinoma? ❑Yes ❑No

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

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

i. Has the patient been previously treated with at least one prior regimen? ❑Yes ❑No

ii. Does the patient have a susceptible isocitrate dehydrogenase-1 (IDH1) mutation detected by an FDA-approved test? ❑Yes ❑No

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

i. Has the patient experienced disease progression or unacceptable toxicity while on Tibsovo? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

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

❑Myelodysplastic Syndromes (MDS)

a. Does the patient have relapsed or refractory myelodysplastic syndromes (MDS)? ❑Yes ❑No

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

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

i. Does the patient have a susceptible isocitrate dehydrogenase-1 (IDH1) mutation detected by an FDA-approved test? ❑Yes ❑No

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

i. Has the patient experienced disease progression or unacceptable toxicity while on Tibsovo? ❑Yes ❑No

❑None of the above

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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.***