BlueCross BlueShield Federal Employee Program

# TRUSELTIQ
# 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 cardholder 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** | | | | | |

## Truseltiq (infigratinib)

****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

What is the patient's total daily dose (mg/day)? _____ total daily dose (mg/day)

1. What is the patient's diagnosis?
   ❑Cholangiocarcinoma
   a. Does the patient have a diagnosis of unresectable locally advanced or metastatic cholangiocarcinoma? ❑Yes ❑No
   ❑Other diagnosis ***(please specify)***:_____

2. Does the prescriber agree to monitor for hyperphosphatemia and agree to withhold Truseltiq and initiate phosphate lowering therapy as clinically indicated? ❑Yes ❑No

3. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No
   ****If YES***, will the patient be advised to use effective contraception during treatment with Truseltiq and for one month after the final dose? ❑Yes ❑No
   **MALE Patient**: Does the patient have a female partner of reproductive potential? ❑Yes***** ❑No
   ****If YES***, will the patient be advised to use effective contraception during treatment with Truseltiq and for one month after the final dose? ❑Yes ❑No

4. Has the patient been on Truseltiq continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   a. Does the patient have a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement, as detected by an FDA-approved test? ❑Yes ❑No
   b. Will a baseline ophthalmological examination be completed and will the patient be monitored for retinal pigment epithelial detachment (RPED)? ❑Yes ❑No
   c. Has the patient had at least one prior therapy? ❑Yes ❑No
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   a. Has the patient experienced disease progression or unacceptable toxicity while on Truseltiq? ❑Yes ❑No
   b. Will the patient be monitored for retinal pigment epithelial detachment (RPED)? ❑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.*** |