BlueCross BlueShield Federal Employee Program

VELCADE 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					

Velcade (bortezomib)

***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 this medication be given by IV infusion (solution request) or by subcutaneous (SC, subQ, SQ, or subcut) injection (pen/syringe request)? ***Select IV infusion or Subcutaneous injection below:***
   ❑IV infusion **OR** ❑Subcutaneous injection (SC, subQ, SQ, or subcut)

2. Is this request for **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***

   ❑**INITIATION** of therapy, please answer the following questions:
   a. What is the patient's diagnosis?
   ❑Light chain (AL) amyloidosis
   i. Will this medication be used in combination with daratumumab/hyaluronidase-fihj (Darzalex Faspro), cyclophosphamide, and dexamethasone? ❑Yes ❑No
   ❑Mantle cell lymphoma (MCL)
   ❑Multiple myeloma (MM)
   ❑Other diagnosis ***(please specify)***: _____

   ❑**CONTINUATION** of therapy, please answer the following questions:
   a. What is the patient's diagnosis?
   ❑Light chain (AL) amyloidosis
   ❑Mantle cell lymphoma (MCL)
   ❑Multiple myeloma (MM)
   ❑Other diagnosis ***(please specify)***: _____
   b. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No

3. Will this medication be used in combination with other proteasome inhibitors (e.g., carfilzomib (Kyprolis) and ixazomib (Ninlaro))? ❑Yes***** ❑No
   ****If YES***, please specify the medication: _____