BlueCross BlueShield Federal Employee Program

VITRAKVI
PRIOR APPROVAL REQUEST

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.

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					

Vitrakvi (larotrectinib)

****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 200 milligrams per day? ❑Yes* ❑No
   If YES, please specify the requested milligrams per day: _____ mg per day

2. Does the patient have a diagnosis of solid tumors with neurotrophic receptor kinase (NTRK) gene fusion? ❑Yes ❑No

2. Does the prescriber agree to monitor AST and ALT? ❑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 Vitrakvi and for one week after the final dose? ❑Yes ❑No

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

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

a. Has the presence of the *NTRK* gene fusion been detected by an FDA-approved test? ❑Yes ❑No

b. Are the patient's solid tumors metastatic? ❑Yes ❑No*
   If NO, is surgical resection likely to result in severe morbidity? ❑Yes ❑No

c. Are there satisfactory alternative treatments? ❑Yes* ❑No
   If YES, has the disease progressed following treatment? ❑Yes ❑No

c. Does the patient have G595R, G623R, G696A, or F617L acquired resistance point mutation? ❑Yes ❑No

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

a. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No