



Federal Employee Program.

# WAYRILZ 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: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R			Physician Signature:		
<b>PHYSICIAN COMPLETES</b>						

## Wayrilz (rilzabrutinib)

\*\*Check [www.fepblue.org/formulary](http://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 800 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 persistent or chronic immune thrombocytopenia (ITP)?  Yes  No

3. Will this medication be used in combination with thrombopoietin receptor agonists?  Yes\*  No

*\*If YES, please specify the medication(s): \_\_\_\_\_*

4. Has the patient been on this medication 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 prescriber agree to monitor the patient's bilirubin and transaminases at baseline and as clinically indicated during treatment?  Yes  No
- b. Has the patient had an inadequate response to at least one of the following therapies: corticosteroids, immunoglobulins, splenectomy, or thrombopoietin receptor agonists?  Yes  No
- c. Does the patient have a baseline platelet count prior to initiation that is less than 50,000 per microliter (50 x 10 to the 9th power per liter)?  Yes  No

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

- a. Does the prescriber agree to monitor the patient's bilirubin and transaminases as clinically indicated?  Yes  No
- b. Has the patient had an improvement in platelet count to 50,000 per microliter (50 x 10 to the 9th power per liter) or greater?  Yes  No