BlueCross BlueShield Federal Employee Program

WELIREG
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					

Welireg (belzutifan)

****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 120 milligrams per day? ❑Yes* ❑No
   If YES, please specify the requested milligrams per day? _____ mg per day
2. Is the patient's hemoglobin greater than or equal to 8 grams per deciliter (g/dL)? ❑Yes ❑No
3. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

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

a. Does the prescriber agree to monitor for anemia and hypoxia before initiation of treatment and periodically throughout treatment? ❑Yes ❑No

b. **MALE Patient**: Does the patient have a female partner of reproductive potential? ❑Yes* ❑No
   If YES, will pregnancy be excluded before the start of treatment? ❑Yes* ❑No
   If YES, will the patient be advised to use effective non-hormonal contraception during treatment with Welireg and for 1 week after the last dose? ❑Yes ❑No

c. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
   If YES, has the patient had a negative pregnancy test? ❑Yes* ❑No
   If YES, will the patient be advised to use effective non-hormonal contraception during treatment with Welireg and for 1 week after the last dose? ❑Yes ❑No

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

a. Does the prescriber agree to monitor for anemia and hypoxia periodically throughout treatment? ❑Yes ❑No

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

c. **MALE Patient**: Does the patient have a female partner of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to use effective non-hormonal contraception during treatment with Welireg and for 1 week after the last dose? ❑Yes ❑No

d. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to use effective non-hormonal contraception during treatment with Welireg and for 1 week after the last dose? ❑Yes ❑No

4. What is the patient's diagnosis?

❑Advanced renal cell carcinoma (RCC)

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ❑Yes ❑No*
   If NO, please answer the following questions:
   i. Has the patient received previous treatment with a PD-1 inhibitor OR PD-L1 inhibitor? ❑Yes ❑No
   ii. Has the patient received previous treatment with a VEGF tyrosine kinase inhibitor? ❑Yes ❑No

❑Von Hippel-Lindau (VHL) disease

a. Does the patient require therapy for associated renal cell carcinoma (RCC), central nervous system (CNS) hemangioblastomas, or pancreatic neuroendocrine tumors (pNET)? ❑Yes ❑No

b. Does the patient require immediate surgery? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 3 – PHYSICIAN COMPLETES

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

❑Pheochromocytoma or paraganglioma (PPGL)

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

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

i. Is the tumor locally advanced, unresectable, or metastatic? ❑Yes ❑No

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

i. Is the tumor advanced, unresectable, or metastatic? ❑Yes ❑No

❑None of the above