BlueCross BlueShield Federal Employee Program

# XOSPATA
# 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** | | | | | |

## Xospata (gilteritinib)

****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

How many tablets will the patient need for a 90 day supply? _____ tablet(s) per 90 days

1. What is the patient's diagnosis?
   - ❑ Refractory Acute Myeloid Leukemia (AML)
   - ❑ Relapsed Acute Myeloid Leukemia (AML)
   - ❑ Other diagnosis ***(please specify)***: _____

2. Does the prescriber agree to monitor electrocardiograms (ECGs), complete blood count (CBC), and creatine phosphokinase? ❑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 Xospata and for six months after the last dose? ❑Yes ❑No

4. **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 Xospata and for four months after the last dose? ❑Yes ❑No

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

   ❑**NO** – this is **INITIATION** of therapy, please answer the follow question:
   a. Is there documentation of the FLT3 mutation as detected by an FDA-approved test? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Has the patient experienced disease progression or unacceptable toxicity while on Xospata? ❑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)<br>Results in 2-3 **minutes**<br>**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.<br>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**<br>(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.<br>The process over the phone takes on average between 4 and 5 minutes. |
| **Fax**<br>(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.<br>The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed.<br>***Please only fax the completed form once as duplicate submissions may delay processing times.*** |