BlueCross BlueShield Federal Employee Program

ZEPZELCA
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					

Zepzelca (lurbinectedin)

****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

1. What is the patient's diagnosis?
   - ❑ Metastatic Small Cell Lung Cancer (SCLC)
   - ❑ Other diagnosis ***(please specify)***:_____

2. Does the prescriber agree to monitor for myelosuppression and hepatotoxicity? ❑Yes ❑No

3. **FEMALE Patient**: Is the patient of child-bearing potential? ❑Yes***** ❑No

   If YES, will the patient be advised to use effective contraception during treatment with Zepzelca and for six months after the last dose? ❑Yes ❑No

   MALE Patient: Does the patient have a partner of child-bearing potential? ❑Yes***** ❑No

   If YES, will the patient be advised to use effective contraception during treatment with Zepzelca and for four months after the last dose? ❑Yes ❑No

4. Has the patient been on Zepzelca 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 patient been treated with platinum-based chemotherapy? ❑Yes***** ❑No

   If YES, did the patient experience disease progression on or after platinum-based chemotherapy? ❑Yes ❑No

   b. Does the patient have baseline neutrophil count of greater than or equal to 1,500 cells per cubic millimeter? ❑Yes ❑No

   c. Does the patient have a baseline platelet count of greater than or equal to 100,000 per cubic millimeter? ❑Yes ❑No

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

   a. Has the patient had any disease progression or unacceptable toxicity while on Zepzelca? ❑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) Results in 2-3 **minutes** **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. 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 (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. The process over the phone takes on average between 4 and 5 minutes.
Fax (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. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***