BlueCross BlueShield of North Carolina

Self-Administered Oncology
Inrebic
Prior Authorization (PA) Request Form

To submit request electronically, please go to covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: 888-446-8535

Mail: Blue Cross NC, ATTN: Part D Coverage Determination
P.O. Box 17509, Winston Salem, NC 27116-7509

Call: 888-298-7552 Blue Medicare Rx
888-296-9790 Blue Medicare HMO/PPO

Incomplete Form May Delay Processing

Prescriber Information		Patient Information
Physician Name:	NPI #:	Patient Name:
Office Contact Person:		Patient ID #:
Office Phone #:	Office Fax #:	Home Phone #:
Address:		Sex: ☐ Female ☐ Male
City: State: Zip:		DOB:

Diagnosis and Medication Information	
Medication Requested:	Diagnosis Code:
Strength and Route of Administration:	Dosing Schedule:
Quantity per 30 Days:	

Please answer questions below

1. Is this request for an expedited review?..... ☐ Yes ☐ No
   Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. *A standard review will have a decision made within 72 hours for a coverage determination.*

2. Please select the diagnosis for the requested medication and answer any associated questions:
   ☐ **Myelofibrosis**
   A. Is the patient an adult?..... ☐ Yes ☐ No
   B. Does the patient have intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis?..... ☐ Yes ☐ No
   ☐ **Other (please specify):** _____

3. Is the patient currently (within the past 180 days) being treated with the requested medication?..... ☐ Yes ☐ No
   A. **If NO**, does the patient have any FDA labeled limitations of use not otherwise supported in NCCN guidelines?..... ☐ Yes ☐ No

4. Is the quantity requested *greater* than the set quantity limit #120 capsules per 30 days?..... ☐ Yes ☐ No
   A. **If YES,** please provide a clinical rationale in support of the quantity requested, including length of time the requested dose has been used (may submit medical records to support this request):_____
   _____

I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature:_____ Date: _____

Updated: 01/01/2023