BlueCross BlueShield
Federal Employee Program

TIKOSYN
(dofetilide)

Pre - PA Allowance

None

Prior-Approval Requirements

Diagnosis

Patient must have the following:

Atrial fibrillation / Atrial flutter

a. Patient **MUST** have tried the preferred product (generic Tikosyn: dofetilide) unless the patient has a valid medical exception (e.g. inadequate treatment response, intolerance, contraindication)

Prior - Approval Limits

Duration 12 months

Prior – Approval *Renewal* Requirements

Same as above

Prior - Approval *Renewal* Limits

Same as above