



**BlueCross
BlueShield**

Federal Employee Program. **AEMCOLO
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: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:																			
Street Address:				Office Street Address:																					
City:	State:	Zip:		City:	State:	Zip:																			
Patient ID:	R <table border="1" style="display: inline-table; width: 150px; height: 1.2em; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																						Physician Signature:		
PHYSICIAN COMPLETES																									

Aemcolo (rifamycin)

*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?

☐ Travelers' diarrhea

a. Is the patient experiencing travelers' diarrhea caused by noninvasive strains of *Escherichia coli* (E coli)? ☐ Yes ☐ No

☐ Other diagnosis (*please specify*): _____

2. Does the patient have a fever greater than 38 degrees Celsius (C) or 100.4 degrees Fahrenheit (F)? ☐ Yes ☐ No

3. Does the patient have bloody stools or signs of a systemic illness? ☐ Yes ☐ No

4. Will Aemcolo be used in combination with Xifaxan (rifaximin)? ☐ 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:

<p>Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST</p>	<p>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.</p>
<p>Phone (4-5 minutes for response)</p>	<p>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 info 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.</p>
<p>Fax (3-5 days for response)</p>	<p>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 PA request cannot be processed. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u></p>

faster...
easier...
better...

Introducing ePA! Online Prior Authorizations in minutes through **Caremark.com/ePA**. Sign up today!

CVS/caremark 