BlueCross BlueShield
Federal Employee Program

ARIKAYCE
PRIOR APPROVAL REQUEST

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.

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

Member 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					

Arikayce

(amikacin liposome inhalation suspension)

****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 vials are needed per day? _____ vial(s) per day

1. What is the patient's diagnosis?
   - ❑ *Mycobacterium Avium* Complex (MAC) lung disease
   - ❑ Other diagnosis ***(please specify)***: _____

2. Does the patient have a history of hyperactive airway disease? ❑Yes* ❑No
   If YES, will the patient receive pre-treatment with an inhaled bronchodilator prior to treatment with Arikayce? ❑Yes ❑No

3. Does the prescriber agree to monitor the patient for respiratory adverse reactions? ❑Yes ❑No

4. **FEMALE Patient**: Is the patient pregnant or of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised of the potential adverse effects to the fetus? ❑Yes ❑No

5. Will Arikayce be given with other antibacterial drugs? ❑Yes ❑No

6. Is the request for **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***

   ❑**INITIATION** of therapy, please answer the following questions:
   - a. Has the diagnosis been confirmed by at least 2 sputum cultures? ❑Yes ❑No
   - b. Is the MAC isolate susceptible to amikacin with a minimum inhibitory concentration (MIC) of less than or equal to 64 mcg/mL? ❑Yes ❑No
   - c. Have alternative treatment options been ruled out? ❑Yes ❑No
   - d. Has the patient had an inadequate response to at least 6 consecutive months of a multidrug regimen? ❑Yes ❑No

   ❑**CONTINUATION** of therapy **(PA renewal)**, please answer the following question:
   - a. Has the patient achieved consecutive monthly negative sputum cultures within the last six months? ❑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.***