BlueCross BlueShield Federal Employee Program

ORAL RINSES
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 cardholder 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					

Oral Rinses

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑ **Aquoral**	❑ **Bocasal**	❑ **Caphosol**	❑ **Gelclair**
❑ **Neutrasal**	❑ **Numoisyn liquid**	❑ **SalivaMax / Salivate Rx**	

Is this request for brand or generic? ❑ Brand ❑ Generic

1. What is the patient's diagnosis?
   - ❑ Mucositis
     a. Is the patient's condition secondary to chemotherapy or radiation? ❑ Yes ❑ No
   - ❑ Stomatitis
     a. Is the patient's condition secondary to chemotherapy or radiation? ❑ Yes ❑ No
   - ❑ Sjogren's syndrome
   - ❑ Xerostomia
     a. Is the patient's condition secondary to chemotherapy or radiation? ❑ Yes ❑ No
   - ❑ Other diagnosis ***(please specify):*** _____

2. Has the patient experienced inadequate response to **TWO** of the following: over-the-counter oral anesthetics, prescription oral anesthetics, saliva substitutes, or Magic mouthwash? ❑ Yes ❑ No