BlueCross BlueShield Federal Employee Program

BREXAFEMME
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: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Brexafemme (ibrexafungerp)

***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

1. What is the patient's diagnosis?

❑Acute treatment of Vulvovaginal Candidiasis (VVC)

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to fluconazole? ❑Yes ❑No

b. Does the patient need more than 4 tablets for a 7 day supply? ***Please select answer below:***

❑**Yes** ***(specify the requested quantity and day supply)***: **quantity**: _____ **AND** **day supply**: _____

❑**No** ***(specify the requested quantity)***: **quantity**: _____

❑Recurrent Vulvovaginal Candidiasis (RVVC)

a. Will Brexafemme be used to reduce the incidence of RVVC? ❑Yes ❑No

b. Does the patient need more than 12 tablets for a 90 day supply? ***Please select answer below:***

❑**Yes** ***(specify the requested quantity and day supply)***: **quantity**: _____ **AND** **day supply**: _____

❑**No** ***(specify the requested quantity)***: **quantity**: _____

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

❑**INITIATION** of therapy, please answer the following question:

i. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to fluconazole? ❑Yes ❑No

❑**CONTINUATION (PA renewal)** of therapy, please answer the following question:

i. Has the prescriber determined that the patient will benefit from an additional six months of therapy for prevention of RVVC? ❑Yes ❑No

❑Other diagnosis ***(please specify)***: _____

2. **Age 17 or Younger**: Is the patient post onset of menses? ❑Yes ❑No

3. Is Brexafemme being used in a footbath? ❑Yes ❑No

4. Is the patient of reproductive potential? ❑Yes***** ❑No

****If YES***, will the patient be advised to use effective contraception during treatment with Brexafemme and for four days after the last dose? ❑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.***