BlueCross BlueShield Federal Employee Program

CHOLESTYRAMINE POWDER 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 provider 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					

Cholestyramine Powder

***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

1. Is this request for the bulk compounding powder or a commercially available cholestyramine product such as Prevalite, Questran, or cholestyramine packets? ❑Bulk compounding powder **OR** ❑Commercially available product

2. Has the patient experienced an inadequate treatment response to the commercially available product? ❑Yes ❑No

3. Will the patient be dosed within the maximum recommended dose of 24 grams per day? ❑Yes ❑No

4. What is the patient's diagnosis?
   - ❑Primary hypercholesterolemia
     - a. Has the patient experienced an inadequate treatment response to diet and exercise? ❑Yes ❑No
     - b. Has the patient experienced an inadequate treatment response to a high intensity HMG-CoA reductase medication? ❑Yes ❑No
     - c. Has the patient experienced an inadequate treatment response to Zetia? ❑Yes ❑No
   - ❑Pruritus associated with partial biliary obstruction
     - a. Has the patient experienced an inadequate treatment response to Colestipol? ❑Yes ❑No
     - b. Has the patient experienced an inadequate treatment response to Rifampin? ❑Yes ❑No
     - c. Has the patient experienced an inadequate treatment response to an opioid antagonist? ❑Yes ❑No
     - d. Has the patient experienced an inadequate treatment response to sertraline? ❑Yes ❑No
   - ❑Other diagnosis ***(please specify):*** _____

5. Does the patient have a history of complete biliary obstruction? ❑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.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.