BlueCross BlueShield Federal Employee Program

# COMPOUND HIGH DOLLAR LIMIT
# 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** | | | | | |

## Compound High Dollar Limit

****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. What dosage form is being compounded? ***Please select dosage form below:***
   ❑Infusion ❑Injectable ❑IV ❑Oral liquid (suspension) ❑Oral solid (buccal, capsule, tablet)
   ❑Topical (cream, gel, ointment) ❑Other dosage type ***(please specify)***: _____

2. **Infusion, Injectable, IV, or Other Dosage Type Request**: Please answer the following question(s):
   a. Is the compound being used for IV antibiotic administration? ❑Yes ❑No*****
   ****If NO***, is the compound being used for the administration of chemotherapy? ❑Yes ❑No

3. What indication is the compound being used for? ***Please select indication below:***
   ❑Infection (infusion, injection, IV)
   ❑Infection (topical use is any application to the skin or mucous membrane, including soaking/foot bath)
   ❑Other reason ***(please specify)***: _____

4. Is the compound being used for cosmetic purposes (including but not limited to anti-wrinkle, hair growth/removal, scar prevention, scar diminishing, skin lightening/tanning, anti-aging)? ❑Yes ❑No

5. **MALE Patient**: Is the compound being used for erectile dysfunction (ED)? ❑Yes ❑No

6. Is the compound being used for performance enhancement? ❑Yes ❑No

7. What ingredients are needed for this compound? ***Please list ingredients below:***

| | | |
|---|---|---|
| | | |
| | | |
| | | |

8. What is the reason that the patient cannot use a commercially available product? ***Please select reason below:***
   ❑Need strength that is not commercially available ❑Omission of dye ❑Omission of flavoring/preservative
   ❑Omission of sweetener ❑Other reason ***(please specify)***: _____

9. Does the prescriber have clinical documentation supporting the need for the compounded product versus the commercially available product? ❑Yes ❑No

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.

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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.*** |


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