BlueCross BlueShield Federal Employee Program.

CRESEMBA
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					

Cresemba (isavuconazonium)

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

Please select dosage form and indicate quantity below:

❑**74.5mg capsules qty _____ per 90 days**	❑**Vials for IV injection qty _____ per 90 days**
❑**186mg capsules qty _____ per 90 days**	❑**Vials for injection via nasogastric (NG) tube qty _____ per 90 days**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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

1. Does the patient have a diagnosis of invasive aspergillosis or invasive mucormycosis (zygomycosis)? ❑Yes* ❑No
   If YES, please select one of the following: ❑Invasive aspergillosis **OR** ❑Invasive mucormycosis (zygomycosis)

2. **Capsules or Vials for Injection via NG Tube Request**: What is the patient's weight? ***Please select answer below:***
   ❑Less than 16 kg (35 lbs) **OR** ❑16 kg (35 lbs) or greater

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

   ❑**INITIATION** of therapy, please answer the following questions:
   a. Has there been laboratory and clinical documentation of causative organism(s)? ❑Yes ❑No
   b. Have or will baseline liver function tests be done prior to initiating therapy? ❑Yes* ❑No
   If YES, will liver function tests be monitored during treatment with dose adjustment based on the severity of liver function? ❑Yes ❑No

   ❑**CONTINUATION** of therapy **(PA renewal)**, please answer the following question:
   a. Will liver function tests be monitored during treatment with dose adjustment based on the severity of liver function? ❑Yes ❑No

BlueCross BlueShield Federal Employee Program.

CRESEMBA
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

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.***