BlueCross BlueShield Federal Employee Program

DARTISLA ODT
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					

Dartisla ODT

(glycopyrrolate)

****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

How many tablets will the patient need for a 60 day supply? _____ tablet(s) per 60 days

1. What is the patient's diagnosis?
   - ❑ Peptic ulcer
   - ❑ Other diagnosis ***(please specify)***: _____
2. Does the patient have glaucoma? ❑Yes ❑No
3. Does the patient have obstructive uropathies including prostatic hypertrophy? ❑Yes ❑No
4. Does the patient have any mechanical obstructive diseases of the gastrointestinal tract such as pyloroduodenal stenosis or strictures? ❑Yes ❑No
5. Does the patient have any gastrointestinal motility disorders such as achalasia, paralytic ileus, or intestinal atony? ❑Yes ❑No
6. Does the patient have a bleeding gastrointestinal ulcer? ❑Yes ❑No
7. Does the patient have active inflammatory or infectious colitis, which can lead to toxic megacolon? ❑Yes ❑No
8. Does the patient have a history of or current toxic megacolon? ❑Yes ❑No
9. Does the patient have myasthenia gravis? ❑Yes ❑No
10. Has the patient been on Dartisla ODT continuously for the last **month**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Is Dartisla ODT being used as adjunctive treatment for the peptic ulcer? ❑Yes ❑No

b. Does the prescriber agree to titrate the patient to a lower dosage strength of another oral dosage form of glycopyrrolate, if clinically appropriate? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a proton pump inhibitor (PPI)? ❑Yes ❑No*****

****If NO***, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a histamine-2 (H2) receptor antagonist? ❑Yes ❑No

d. Has the patient had an inadequate treatment response to a lower dosage strength of an oral glycopyrrolate product such as glycopyrrolate 1mg tablet? ❑Yes ❑No*****

****If NO***, is the patient currently receiving the 2mg dosage strength of another glycopyrrolate oral tablet? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. Has the patient had an improvement in peptic ulcer symptoms with therapy? ❑Yes ❑No

b. Is the patient able to take another oral dosage form of glycopyrrolate? ❑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.***