



**BlueCross  
BlueShield**

## TOPICAL PRODUCTS W/QUANTITY LIMITS

### Federal Employee Program. PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

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**

| Patient Information (required) |                                                                    |      |  | Provider Information (required) |        |             |
|--------------------------------|--------------------------------------------------------------------|------|--|---------------------------------|--------|-------------|
| Date:                          |                                                                    |      |  | Provider Name:                  |        |             |
| Patient Name:                  |                                                                    |      |  | Specialty:                      |        | NPI:        |
| Date of Birth:                 | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |      |  | Office Phone:                   |        | Office Fax: |
| Street Address:                |                                                                    |      |  | Office Street Address:          |        |             |
| City:                          | State:                                                             | Zip: |  | City:                           | State: | Zip:        |
| Patient ID:                    | R <input type="text"/>                                             |      |  | Physician Signature:            |        |             |
| <b>PHYSICIAN COMPLETES</b>     |                                                                    |      |  |                                 |        |             |

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

#### Please select medication(s) and provide quantity:

| Select Medication:                                                                                   | Requested Quantity per 90 days |
|------------------------------------------------------------------------------------------------------|--------------------------------|
| <input type="checkbox"/> calcipotriene CREAM 0.005% (Dovonex)                                        | units _____ per 90 days        |
| <input type="checkbox"/> calcipotriene FOAM 0.005% (Sorilux)                                         | units _____ per 90 days        |
| <input type="checkbox"/> calcipotriene/betamethasone dipropionate CREAM 0.005/0.064% (Wynzora)       | units _____ per 56 days        |
| <input type="checkbox"/> calcipotriene/betamethasone dipropionate FOAM 0.005/0.064% (Enstilar)       | units _____ per 90 days        |
| <input type="checkbox"/> calcipotriene/betamethasone dipropionate OINTMENT 0.005/0.064% (Taclonex)   | units _____ per 90 days        |
| <input type="checkbox"/> calcipotriene/betamethasone dipropionate SUSPENSION 0.005/0.064% (Taclonex) | units _____ per 90 days        |
| <input type="checkbox"/> halobetasol propionate LOTION 0.01% (Bryhali)                               | grams _____ per 90 days        |
| <input type="checkbox"/> halobetasol propionate TOPICAL FOAM 0.05% (Lexette)                         | grams _____ per 90 days        |
| <input type="checkbox"/> halobetasol propionate/tazarotene lotion 0.01/0.045% (Duobrii)              | grams _____ per 90 days        |

\*Check [www.fepblue.org/formulary](http://www.fepblue.org/formulary) to confirm which medication is part of the patient's benefit

**\*\*Non-covered branded medications must go through prior authorization and the formulary exception process**

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

1. What is the patient's diagnosis?

☐ Plaque psoriasis

☐ Other diagnosis (*please specify*): \_\_\_\_\_

2. **Bryhali or Lexette Request:** Does the patient have a contraindication to or have they had either an inadequate response or intolerance to a generic halobetasol topical product? ☐ Yes ☐ No

3. **Duobrii Request:** Has the patient been on Duobrii continuously for the last **6 months**, excluding samples? *Select answer below:*

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

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a generic halobetasol topical product? ☐ Yes ☐ No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a generic tazarotene topical product? ☐ Yes ☐ No

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

a. Has the patient's condition improved with therapy? ☐ 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:

|                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                |
|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Electronically Online</b><br>(ePA)<br>Results in 2-3 minutes<br><b>FASTEST AND EASIEST</b> | Now you can get responses to drug Prior Authorization requests <b>securely</b> online. <b>Online</b> submissions may receive <b>instant</b> responses and do not require faxing or phone calls.<br>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 <b>Caremark.com/ePA</b> .                           |
| <b>Phone</b><br>(4-5 minutes for response)                                                    | The FEP Clinical Call Center can be reached at <b>(877)-727-3784</b> 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.<br>The process over the phone takes on average between 4 and 5 minutes. |
| <b>Fax</b><br>(3-5 days for response)                                                         | Fax the attached form to <b>(877)-378-4727</b> . 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.<br><b><u>Please only fax the completed form once as duplicate submissions may delay processing times.</u></b>               |

|                                              |                                                                                                           |
|----------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>faster...<br/>easier...<br/>better...</b> | Introducing ePA! Online Prior Authorizations in minutes through <b>Caremark.com/ePA</b> . Sign up today!  |
|                                              | <b>CVS/caremark</b>  |