BlueCross BlueShield
Federal Employee Program

FILSUVEZ
PRIOR APPROVAL REQUEST

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.

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: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Filsuvez (birch triterpenes)

***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 brand or generic? ❑Brand ❑Generic

2. Is Filsuvez being used to treat wounds associated with dystrophic and junctional epidermolysis bullosa (EB)? ❑Yes ❑No

3. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

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

   a. Does the patient have any active infection, active squamous cell carcinoma, or history of squamous cell carcinoma in the targeted wound(s)? ❑Yes ❑No

   b. Is Filsuvez being prescribed by or in consultation with a dermatologist or a provider who specializes in EB? ❑Yes ❑No

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

   a. Has the patient had clinical improvement such as partial or complete wound closure while on Filsuvez? ❑Yes ❑No