BlueCross BlueShield Federal Employee Program

FUROSCIX
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					

Furoscix injection for subcutaneous use

(furosemide)

****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 kits will the patient need for a 90 day supply? _____ kit(s) per 90 days

1. What is the patient's diagnosis?
   - ❑Chronic heart failure
   - ❑Chronic kidney disease including nephrotic syndrome
   - ❑None of the above
2. Does the prescriber agree to use Furoscix short-term only **AND** replace with oral diuretics as soon as practical? ❑Yes ❑No
3. Does the patient have edema? ❑Yes ❑No
4. Does the patient have a clinical reason for requiring Furoscix such as reduced responsiveness to oral diuretics*? ❑Yes ❑No
   Oral diuretics include (not all inclusive) bumetanide, furosemide, or torsemide.
5. Is the patient a candidate for outpatient treatment? ❑Yes ❑No