BlueCross BlueShield Federal Employee Program

GRASTEK
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					

Grastek

(timothy grass pollen allergen extract)

****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 90 day supply? _____ tablet(s) per 90 days

1. What is the patient's diagnosis?
   - ❑ Cross-reactive grass pollen-induced allergic rhinitis
   - ❑ Timothy grass *(phleum pretense)* pollen-induced allergic rhinitis
   - ❑ Other diagnosis ***(please specify):*** _____

2. Does the patient have severe, unstable, or uncontrolled asthma by having a significantly impaired activity level or using a rescue inhaler greater than two days or more per week? ❑Yes ❑No

3. Does the patient have eosinophilic esophagitis? ❑Yes ❑No

4. Will Grastek be given with other allergen immunotherapies? ❑Yes* ❑No
   If YES, specify medication(s): _____

5. Has the patient been on Grastek continuously for the last **6 months**, excluding samples? ❑Yes ❑No*
   If NO, please answer **ALL of the following** questions:
   a. Does the patient have a skin test or an in vitro test which confirmed pollen-specific IgE antibodies for Timothy grass or cross reactive grass pollen? ❑Yes ❑No
   b. Does the physician have training and experience in the treatment of allergic diseases? ❑Yes ❑No
   c. Has the patient shown unacceptable response to at least one oral or intranasal steroid? ❑Yes ❑No
   d. Has the patient shown unacceptable response to at least one oral antihistamine? ❑Yes ❑No
   e. Has the patient been prescribed or given auto-injectable epinephrine? ❑Yes* ❑No
      If YES, has the patient been instructed on the use of the auto-injectable epinephrine? ❑Yes ❑No
   f. Does the patient have a history of severe local reaction to sublingual allergen immunotherapy? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Grastek – FEP MD Fax Form Revised 11/2/2021

BlueCross BlueShield
Federal Employee Program

GRASTEK
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.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Grastek – FEP MD Fax Form Revised 11/2/2021