

## HEPSERA 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 complete	ed form.			Fa	ax: 1-877-378-4727	
Patient In	formation (require	ed)	Pro	<b>Provider Information</b> (required)		
Date:			Provider Name:			
Patient Name:			Specialty:	NPI:		
Date of Birth:	Sex: Male	e 🛛 Female	Office Phone:	Office Fax		
Street Address:			Office Street Addres	SS:		
City:	State:	Zip:	City:	State:	Zip:	
Patient ID:			Physician Signature:	Physician Signature:		
		PHYSICIA	N COMPLETES			
For Standard Option patie	nts GENERIC Hepsera	(adefovir) is th	e preferred product. Plea	se consider prescribing th	ne preferred product.	

For Standard Option patients GENERIC Hepsera (adefovir) is the preferred product. Please consider prescribing the preferred product. Standard Option patients who switch to generic Hepsera will be eligible for 2 copays at no cost in the benefit year.

## Hepsera (adefovir)

\*\*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

Federal Employee Program.

**BRAND Hepsera Request (Standard Option Patient)**: Would you like to switch the patient to the preferred product, adefovir (generic Hepsera)? □Yes, switch to adefovir (generic Hepsera) □No\*

\**If NO*, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to adefovir (generic Hepsera)? *Please select answer below:* 

□Yes, please specify: \_

■No: Is there a clinical reason for not trying adefovir (generic Hepsera)? ■Yes\* ■No \**If YES*, please specify: \_\_\_\_\_

1. Does the patient have a diagnosis of Hepatitis B (HBV) infection? □Yes □No\* *\*If NO*, please specify other diagnosis:\_\_\_\_\_



## BlueShield. HEPSERA Federal Employee Program. PRIOR APPROVAL REQUEST

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 <b>securely</b> online. <b>Online</b> submissions may receive <b>instant</b> 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 <b>Caremark.com/ePA.</b>
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. <u>Please only fax the completed form once as</u> <u>duplicate submissions may delay processing</u> <u>times.</u>

faster	Introducing ePA! Online Prior
easier	Authorizations in minutes through Caremark.com/ePA. Sign up today!
better	Caremark.com/erA. Sign up today:
	CVS/caremark <sup>®</sup>

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. Hepsera – FEP MD Fax Form Revised 3/18/2022