



Federal Employee Program.

ANTI-INFLAMMATORY PAIN POWDERS 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: <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			Physician Signature:		
PHYSICIAN COMPLETES						

Anti-Inflammatory Pain Powders

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

Please select powder(s) below:

- | | | |
|--|--|---|
| <input type="checkbox"/> Celecoxib Powder | <input type="checkbox"/> Flurbiprofen Powder | <input type="checkbox"/> Meloxicam Powder |
| <input type="checkbox"/> Diclofenac Powder | <input type="checkbox"/> Ibuprofen Powder | <input type="checkbox"/> Naproxen Powder |
| <input type="checkbox"/> Fenoprofen Powder | <input type="checkbox"/> Ketoprofen Powder | <input type="checkbox"/> Tramadol Powder |

*Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

1. What is the dosage form the powder will be compounded into? *Please select answer below:*

- ☐ Injectable
- ☐ Ophthalmic
- ☐ Oral solid (tablet/capsule/buccal)
- ☐ Oral liquid (suspension)
- ☐ Topical (cream/gel/ointment/patch/solution)
- ☐ Other dosage form (*please specify*): _____

2. What is the patient's diagnosis (*please specify*)? _____

3. Does the requested dose/strength exceed the maximum FDA-approved dose/strength for the requested product? ☐ Yes ☐ No

4. Is the requested dose commercially available? ☐ Yes ☐ No

5. What is the concentration of the final product? _____

6. Please list the ingredients (recipe) and **amounts of each ingredient (or final strength of active ingredient)** for the desired compound request:



**BlueCross
BlueShield**

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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:

<p>Electronically Online (ePA)</p> <p>Results in 2-3 minutes FASTEST AND EASIEST</p>	<p>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.</p>
<p>Phone</p> <p>(4-5 minutes for response)</p>	<p>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 info 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.</p>
<p>Fax</p> <p>(3-5 days for response)</p>	<p>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 PA request cannot be processed. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u></p>

**faster...
easier...
better...**

Introducing ePA! Online Prior Authorizations in minutes through **Caremark.com/ePA**. Sign up today!

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