



**BlueCross
BlueShield**

Federal Employee Program

TOPICAL ANTIFUNGALS 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 cardholder 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							

Topical Antifungals

**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

Jublia Request: Will the patient need more than 16mL (4x4mL bottles or 2x8mL bottles) for an 84 day supply? ☐ Yes* ☐ No

***If YES,** please specify: ☐ Jublia 4ml # of bottles _____ ☐ Jublia 8ml # of bottles _____

Kerydin Request: Will the patient need more than 20mL (5x4mL bottles or 2x10mL bottles) for an 84 day supply? ☐ Yes* ☐ No

***If YES,** please specify: ☐ Kerydin 4 ml # of bottles _____ ☐ Kerydin 10 ml # of bottles _____

1. What is the patient's diagnosis?

☐ Onychomycosis

a. Where is the fungal infection located? ☐ Fingernail(s) ☐ Toenail(s)

☐ Other location (*please specify*): _____

☐ Other fungal infection (*please specify*): _____

☐ Other diagnosis (*please specify*): _____

2. Has there been laboratory determination and clinical documentation of either *Trichophyton rubrum* (*T.rubrum*) or *Trichophyton mentagrophytes* (*T.mentagrophytes*)? ☐ Yes* ☐ No

***If YES,** please select one of the following: ☐ *Trichophyton mentagrophytes* **OR** ☐ *Trichophyton rubrum*

3. Has the patient had an inadequate treatment response, intolerance, or contraindication to a prescription oral therapy? ☐ Yes* ☐ No

***If YES,** please select all that apply:

Prescription Oral Therapy:

☐ Diflucan (fluconazole)

☐ Lamisil (terbinafine)

☐ Sporanox (itraconazole)

☐ GrisPeg (griseofulvin)

☐ Nizoral (ketoconazole)

☐ Vfend (voriconazole)

☐ Other prescription oral therapy (*please specify*): _____

4. Has the patient had an inadequate treatment response, intolerance, or contraindication to a topical antifungal therapy? ☐ Yes* ☐ No

***If YES,** please select all that apply:

Topical Antifungal Therapy:

☐ Jublia (efinaconazole)

☐ Luzu (luliconazole)

☐ Penlac, Loprox (ciclopirox)

☐ Kerydin (tavaborole)

☐ Oxistat (oxiconazole)

☐ Spectazole (econazole)

☐ Other topical antifungal therapy (*please specify*): _____



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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:

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. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u>

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	CVS/caremark 