BlueCross BlueShield
Federal Employee Program

KLISYRI
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					

Klisyri ointment

(tirbanibulin)

****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

Will the patient need more than 5 packets over the course of a year? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ packets over the course of a year

1. Does the patient have a diagnosis of actinic keratosis (actinic keratoses)? ❑Yes ❑No

2. Is this **INITIATION** or **CONTINUATION** of therapy with Klisyri? ***Please select answer below:***

❑**INITIATION** of therapy, please answer the following question:

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical purine analog such as fluorouracil? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical antineoplastic such as imiquimod? ❑Yes ❑No

❑**CONTINUATION** of therapy (PA renewal), please answer the following question:

a. Has the patient had improvement in lesion(s) from their last course of therapy? ❑Yes ❑No