BlueCross BlueShield Federal Employee Program.

LIQREV / REVATIO
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

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

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

Please select medication: ❑**Liqrev (sildenafil)** ❑**Revatio (sildenafil)**

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

Is this request for brand or generic? ❑Brand ❑Generic

1. **BRAND Revatio Request (Standard Option Patient)**: Would you like to participate in this program and switch the patient to sildenafil (**generic** Revatio)? ❑Yes, switch to sildenafil (**generic** Revatio) ❑No*****

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

   ❑**Yes** ***(specify result)***: _____

   ❑**No**: Is there a clinical reason for not trying sildenafil (**generic** Revatio)? ❑Yes***** ❑No

   If YES, please specify: _____

2. **GENERIC Revatio Request (Standard Option Patient):** Is sildenafil (**generic** Revatio) being requested as a change from **BRAND** Revatio to allow the member access to their copay benefit? ❑Yes, change from **BRAND** Revatio ❑No

3. Does the prescriber agree to counsel and evaluate the patient for sudden loss of vision or hearing associated with this medication? ❑Yes ❑No

4. Will this medication be used in combination with another *****phosphodiesterase inhibitor (PDE-5 inhibitor)? ❑Yes ❑No

   If YES, please specify medication: _____

   PDE-5 Inhibitors: Viagra/Revatio (sildenafil), Cialis/Adcirca (tadalafil), Levitra/Staxyn (vardenafil), Stendra (avanafil)

5. Will this medication be used in combination with *****guanylate cyclase (GC) stimulators? ❑Yes***** ❑No

   If YES, please specify medication: _____

   GC Stimulators: Adempas (riociguat) and Verquvo (vericiguat)

6. Will this medication be used in combination with *****alpha blockers? ❑Yes***** ❑No

   If YES, please specify medication: _____

   Alpha Blockers: alfuzosin (Uroxatral), doxazosin (Cardura/XL), prazosin (Minipress), silodosin (Rapaflo), tamsulosin (Flomax, Jalyn), terazosin (Hytrin), etc

7. Will this medication be used in combination with any *****nitrates in any form? ❑Yes***** ❑No

   If YES, please specify medication: _____

   Nitrates: isosorbide dinitrate (Isordil), isosorbide mononitrate (Imdur, Ismo), nitroglycerin tablets, capsules, or patches, (Nitro-Dur), and isosorbide dinitrate/hydralazine (BiDil)

8. What is the patient's diagnosis?

   ❑Erectile dysfunction (ED)/Impotence

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Raynaud's syndrome

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a *****calcium channel blocker? ❑Yes ❑No

****Calcium Channel Blockers: Katerzia/Norvasc (amlodipine), Cardizem/Cartia/Dilacor/Taztia/Tiazac /Matzim/Dilt-XR (diltiazem), Plendil (felodipine),Dynacirc (isradipine), Cardene (nicardipine), Adalat/Afeditab/Nifedical/Nifediac/Procardia (nifedipine), Nymalize (nimodipine), Sular (nisoldipine), Calan/Verelan (verapamil).***

ii. Does the patient have an intolerance, contraindication or have they had an inadequate treatment response to an *****alpha adrenergic receptor blocker? ❑Yes ❑No

****Alpha Adrenergic Receptor Blockers: alfuzosin (Uroxatral), doxazosin (Cardura/XL), prazosin (Minipress), silodosin (Rapaflo), tamsulosin (Flomax, Jalyn), terazosin (Hytrin) etc.***

iii. Does the patient have an intolerance or contraindication or have they had an inadequate response to an *****angiotensin II receptor antagonist? ❑Yes ❑No

****Angiotensin II Receptor Antagonists: Edarbi (azilsartan), Atacand (candesartan), Teveten (eprosartan), Avapro (irbesartan), Cozaar (losartan), Benicar (olmesartan), Micardis (telmisartan), Diovan (valsartan).***

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Have the patient's symptoms improved or stabilized with therapy? ❑Yes ❑No

❑Pulmonary hypertension **OR** ❑Pulmonary Arterial Hypertension (PAH) (WHO Group 1)

a. Is the patient's pulmonary hypertension classified by *****WHO as Group 1? ❑Yes ❑No

****WHO Group 1 includes: congenital heart disease, connective tissue disease, drugs or toxins induced, heritable PAH, HIV infection, idiopathic/unknown cause, portal hypertension, pulmonary veno-occlusive disease (PVOD), pulmonary capillary hemangiomatosis (PH), persistent pulmonary hypertension of the newborn (PPHN), and schistosomiasis.CH), persistent pulmonary hypertension of the newborn (PPHN), and schistosomiasis***

b. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. **Age 17 or younger**: Which NYHA functional class is the child? ***Please select class below:***

❑Asymptomatic (Class I)

❑Mild tachypnea or diaphoresis with feeding (Class II)

❑Marked tachypnea or diaphoresis with feeding, prolonged feeding time with growth failure or marked dyspnea on exertion (Class III)

❑Symptoms such as tachypnea, retractions, grunting, or diaphoresis at rest (Class IV)

ii. **Age 18 or older**: Which level of activity causes the patient to experience shortness of breath or fatigue? ***Answer below:***

❑No symptoms and no limitations in ordinary physical activity (Class I)

❑Mild symptoms and slight limitation during ordinary activity (Class II)

❑Marked limitation in activity due to symptoms, even during less than ordinary activity (Class III)

❑Experience shortness of breath and fatigue while at rest (Class IV)

iii. Has this medication been prescribed by or recommended by either a cardiologist or pulmonologist? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Have the patient's symptoms improved or stabilized with therapy? ❑Yes ❑No

❑Other ***(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. ***Please only fax the completed form once as duplicate submissions may delay processing times.***