



**BlueCross
BlueShield**

Federal Employee Program

ANTIFUNGAL / ANTIBIOTICS POWDERS

PRIOR APPROVAL REQUEST

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.

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**

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						

Antifungal and Antibiotic Powders

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

Please select medication:

- | | | |
|--|--|--|
| ☐ Econazole Powder | ☐ Mupirocin Powder | ☐ Tobramycin Powder |
| ☐ Ketoconazole Powder | ☐ Nystatin Powder (Nyamyc/Nystop) | ☐ Vancomycin Powder |

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

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

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

2. Nystatin Powder Request: Please answer the following questions:

- a. Will Nystatin be used as an ingredient in a compound? ☐ Yes ☐ No
- b. How many grams will the patient need for a 90 day supply? _____ gram(s) per 90 days

3. What is the patient's diagnosis?

- ☐ Candidiasis
☐ Tinea corporis
☐ Tinea cruris
☐ Tinea pedis
☐ Tinea versicolor
☐ Other diagnosis (*please specify*): _____

4. Is this request for an antifungal or antibiotic powder for compounding? ☐ Yes ☐ No

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

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

7. Will the requested product be used in a foot bath? ☐ Yes ☐ No

8. What is the final dose/strength being requested (*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>

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

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

CVS/caremark 