BlueCross BlueShield Federal Employee Program

H. *pylori* INFECTION AGENTS 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					

The Blue Cross & Blue Shield Service Benefit Plan does NOT require a prior approval for ONE course of therapy in a 12-month period.
Prior Approval is only required if the patient will EXCEED ONE course of therapy in a 12-month period.

H. *pylori* Infection Agents

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

Please select medication:

❑**Lansoprazole, amoxicillin, clarithromycin,**	❑**Talicia (omeprazole, amoxicillin, rifabutin)**
❑**Omeclamox-Pak (omeprazole, clarithromycin, amoxicillin)**	❑**Voquezna Dual Pak (vonoprazan, amoxicillin)**
❑**Pylera (bismuth subcitrate, metronidazole, tetracycline)**	❑**Voquezna Triple Pak (vonoprazan, amoxicillin, clarithromycin)**

****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. **Lansoprazole, Omeclamox, Pylera, or Talicia Request:** Please answer the following question:
   a. How many capsules are needed for a 14 day supply? _____ capsule(s) per 14 days
2. **Voquezna Request**: Does the patient need more than one course of therapy (14 blister cards for 14 days)? ❑Yes* ❑No
   If YES, please specify: _____
3. Has the patient filled any of the medications below within the last 365 days? ❑Yes* ❑No
   If YES, please select medication below:
   ❑Lansoprazole, amoxicillin, clarithromycin, ❑Talicia (omeprazole, amoxicillin, rifabutin)
   ❑Omeclamox-Pak (omeprazole, clarithromycin, amoxicillin) ❑Voquezna dual pak (vonoprazan, amoxicillin)
   ❑Pylera (bismuth subcitrate, metronidazole, tetracycline) ❑Voquezna triple pak (vonoprazan, amoxicillin, clarithromycin)
   ❑Multiple products ***(please specify)***: _____
4. Is the patient being treated with this medication for *H. pylori* infection? ❑Yes ❑No*
   If NO, please specify: _____
5. Has the diagnosis been confirmed by endoscopy, breath testing or stool testing? ❑Yes ❑No
6. **Lansoprazole, Omeclamox, or Voquezna Triple Pak Request:** Is the patient clarithromycin- resistant? ❑Yes ❑No
7. **Pylera Request**: Will Pylera be co-administered with omeprazole (Prilosec)? ❑Yes ❑No
8. **Talicia Request**: Please answer the following questions:
   a. Is the patient suspected to be clarithromycin-resistant? ❑Yes ❑No
   b. Will Talicia be used in combination with certain HIV medications, such as rilpivirine and delavirdine? ❑Yes ❑No

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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.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.