



Federal Employee Program. **RAGWITEK** 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.

Form with two main sections: Patient Information (required) and Provider Information (required). Includes fields for Date, Patient Name, Date of Birth, Sex, Street Address, City, State, Zip, Patient ID, Provider Name, Specialty, NPI, Office Phone, Office Fax, Office Street Address, City, State, Zip, and Physician Signature. A large 'R' is present in the Patient ID field. A footer reads 'PHYSICIAN COMPLETES'.

**Ragwitek**

(short ragweed pollen allergen extract)

\*\*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

How many tablets will the patient need for a 90 day supply? \_\_\_\_\_ tablet(s) per 90 days

1. What is the patient's diagnosis?

Short ragweed pollen-induced allergic rhinitis

Other diagnosis (please specify): \_\_\_\_\_

2. Does the patient have severe, unstable, or uncontrolled asthma by having a significantly impaired activity level or using a rescue inhaler greater than two days or more per week? Yes No

3. Does the patient have eosinophilic esophagitis? Yes No

4. Will Ragwitek be given with other allergen immunotherapies? Yes\* No

\*If YES, specify medications: \_\_\_\_\_

5. Has the patient been on Ragwitek continuously for the last **6 months**, excluding samples? Yes No\*

\*If NO, please answer the following questions:

a. Does the patient have a positive skin test or an in vitro test which confirmed pollen-specific IgE antibodies for short ragweed pollen? Yes No

b. Does the physician have training and experience in the treatment of allergic diseases? Yes No

c. Has the patient shown unacceptable response to at least one oral or intranasal steroid? Yes No

d. Has the patient shown unacceptable response to at least one oral antihistamine? Yes No

e. Has the patient been prescribed or been given an auto-injectable epinephrine? Yes\* No

\*If YES, has the patient been instructed on the use of the auto-injectable epinephrine? Yes No

f. Does the patient have a history of severe local reaction to sublingual allergen immunotherapy? Yes No



**BlueCross  
BlueShield**

Federal Employee Program.

**RAGWITEK**

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Service Benefit Plan  
Prior Approval  
P.O. Box 52080 MC 139  
Phoenix, AZ 85072-2080  
Attn. Clinical Services  
Fax: 1-877-378-4727

Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

<p><b>Electronically Online (ePA)</b> Results in 2-3 minutes <b>FASTEST AND EASIEST</b></p>	<p>Now you can get responses to drug Prior Authorization requests <b>securely</b> online. <b>Online</b> submissions may receive <b>instant</b> 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 <b>Caremark.com/ePA.</b></p>
<p><b>Phone</b> (4-5 minutes for response)</p>	<p>The FEP Clinical Call Center can be reached at <b>(877)-727-3784</b> 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.</p>
<p><b>Fax</b> (3-5 days for response)</p>	<p>Fax the attached form to <b>(877)-378-4727.</b> 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. <b><u>Please only fax the completed form once as duplicate submissions may delay processing times.</u></b></p>

<p><b>faster... easier... better...</b></p>	<p>Introducing ePA! Online Prior Authorizations in minutes through <b>Caremark.com/ePA.</b> Sign up today!</p> <p><b>CVS/caremark</b> </p>
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