BlueCross BlueShield Federal Employee Program

SUBSYS
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 cardholder 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					

Subsys (fentanyl sublingual spray)

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

Please select strength and indicate the quantity (#units) requested per 90 days:

❑ **100mcg***	**qty _____ units per 90 days**	❑ **600mcg**	**qty _____ units per 90 days**
❑ **200mcg**	**qty _____ units per 90 days**	❑ **800mcg**	**qty _____ units per 90 days**
❑ **300mcg**	**qty _____ units per 90 days**	❑ **1200mcg (2x600mcg)**	**qty _____ units per 90 days**
❑ **400mcg**	**qty _____ units per 90 days**	❑ **1600mcg (2x800mcg)**	**qty _____ units per 90 days**

Initial PA request MUST be for 100mcg even if patient is established on another fentanyl product

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

1. What is the patient's diagnosis?
   ❑Breakthrough cancer pain
      a. What is the location or type of cancer being treated? _____
   ❑Other diagnosis ***(please specify)***: _____
2. Will the patient be using Subsys with another immediate release fentanyl product? ❑Yes ❑No
3. Are both the patient and prescribing healthcare professional enrolled in the TIRF REMS Access program? ❑Yes ❑No
4. Has the patient been on Subsys therapy continuously for the last **4 months**, excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   a. Is the prescribing healthcare professional an oncologist or pain management specialist who is knowledgeable of and skilled in the use of Schedule II opioids to treat cancer pain? ❑Yes ❑No
   b. Is the patient already receiving around-the-clock opioid analgesic therapy for underlying persistent cancer pain for at least one week? ❑Yes ❑No
   c. Is the patient taking one of the following listed therapies for at least one week or longer and therefore considered opioid tolerant: at least 60mg oral morphine/day, at least 25mcg transdermal fentanyl/hr, at least 30mg of oral oxycodone daily, at least 8mg oral hydromorphone daily **OR** an equianalgesic dose of another opioid? ❑Yes ❑No*
      ***If NO**, did the patient require lower doses of the above to achieve tolerance because of age or renal status? ❑Yes ❑No
   d. Is the patient changing from therapy with Actiq? ❑Yes* ❑No
      ***If YES**, what strength of Actiq is the patient currently using? _____ mcg

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   a. Has the patient remained on around-the-clock opioid therapy? ❑Yes ❑No
   b. Is the prescriber an oncologist or pain specialist? ❑Yes ❑No

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. Subsys – FEP CSU_MD Fax Form Revised 11/1/2018

BlueCross BlueShield
Federal Employee Program

SUBSYS
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

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 info 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 PA 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. Subsys – FEP CSU_MD Fax Form Revised 11/1/2018