BlueCross BlueShield Federal Employee Program.

TAMIFLU
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					

Tamiflu (oseltamivir)

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

Please select form and strength:

❑30 mg capsule ❑45 mg capsule ❑75 mg capsule ❑6 mg/5 mL suspension

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

*****Prior Approval is only required if the patient will EXCEED TWO 5-day courses of therapy in a 12-month period.**

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

1. Is Tamiflu being used for prophylaxis (prevention) of influenza or for the treatment of influenza? ❑Yes* ❑No

If YES, please select answer below:

❑Prophylaxis (prevention) of influenza

a. Is the patient at high risk for complications due to influenza, immunocompromised, or residing in an institutional setting such as a long-term care facility? ❑Yes* ❑No

If YES, please select answer below:

❑High risk for complications due to influenza

i. Which dosage form is being requested? ***Please select answer below***:

❑Capsule: How many capsules will the patient need for a 60 day supply? _____ per 60 days

❑Suspension: How many milliliters will the patient need for a 60 day supply? _____ per 60 days

❑Immunocompromised OR ❑Residing in an institutional setting such as long-term care facility

i. Which dosage form is being requested? ***Please select answer below:***

❑Capsule: How many capsules will the patient need for a 180 day supply? _____ per 180 days

❑Suspension: How many milliliters will the patient need for a 180 day supply? _____ per 180 days

❑Treatment of influenza

a. Has the patient had an onset of flu symptoms within the previous 48 hours? ❑Yes ❑No

b. Which dosage form is being requested? ***Please select answer below***:

❑Capsule: How many capsules will the patient need for a 30 day supply? _____ per 30 days

❑Suspension: How many milliliters will the patient need for a 30 day supply? _____ per 30 days

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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.***