BlueCross BlueShield Federal Employee Program

TASMAR
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					

Tasmar (tolcapone)

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

****Non-covered branded medications must go through prior authorization and the formulary exception process**

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

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

How many tablets are needed every 90 days? _____ tablet(s) per 90 days

1. What is the patient's diagnosis?
   - ❑ Parkinson's Disease
   - ❑ Other diagnosis ***(please specify)***:_____
2. Will the patient be monitored for liver failure and hepatic dysfunction? ❑Yes ❑No
3. Will Tasmar be discontinued if the patient's ALT or AST levels exceed two times the upper limit of normal? ❑Yes ❑No
4. Will Tasmar be used in combination with carbidopa/levodopa? ❑Yes ❑No
5. Has the patient been on Tasmar continuously for the last **4 months**, excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

   a. Has the patient had inadequate control of their Parkinson's symptoms on maximum tolerated doses of oral carbidopa/levodopa therapy? ❑Yes ❑No

   b. Does the patient have a contraindication to or have they had either an inadequate response or intolerance to other adjunctive Parkinson's therapy? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

   a. Has the patient had an improvement in Parkinson's symptoms? ❑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 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.***