



**BlueCross  
BlueShield**

Federal Employee Program. **UPNEEQ**

**PRIOR APPROVAL REQUEST**

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.

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**

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	<b>R</b> <div style="border: 1px solid black; width: 150px; height: 1.2em; display: inline-block;"></div>			Physician Signature:		
<b>PHYSICIAN COMPLETES</b>						

**Upneeq**

(oxymetazoline hydrochloride ophthalmic solution)

\*Check [www.fepblue.org/formulary](http://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 single-use containers will the patient need for a 90 day supply? \_\_\_\_\_ container(s) per 90 days

1. What is the patient's diagnosis?

☐ Acquired blepharoptosis (droopy eyelid)

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

2. Will Upneeq be prescribed or recommended by an ophthalmologist? ☐ Yes ☐ No

3. Does the prescriber agree to advise the patient of the signs and symptoms of acute angle closure glaucoma and to seek medical care if needed? ☐ Yes ☐ No

4. Is Upneeq being used exclusively for cosmetic use? ☐ Yes ☐ No

5. Has the patient been on Upneeq continuously for the last **2 months**, excluding samples? *Please select answer below:*

☐ **NO** – this is **INITIATION** of therapy, please answer the following question:

a. Does the condition impair the patient's visual field? ☐ 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 symptoms such as improved field of vision? ☐ 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:

<p><b>Electronically Online</b> (ePA) 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>

**faster...  
easier...  
better...**

Introducing ePA! Online Prior Authorizations in minutes through **Caremark.com/ePA**. Sign up today!

**CVS/caremark** 