BlueCross BlueShield
Federal Employee Program

XDEMVY
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					

Xdemvy ophthalmic solution

(lotilaner)

****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

1. Is this request for brand or generic? ❑Brand ❑Generic
2. Will the patient need more than 4 bottles over the course of a year? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ bottles over the course of a year
3. Does the patient have a diagnosis of demodex blepharitis? ❑Yes ❑No
4. Has the presence of demodex mites been confirmed? ❑Yes ❑No
5. Has the prescriber determined the presence and density of demodex mites is causing or contributing to the patient's blepharitis symptoms? ❑Yes ❑No
6. Has the patient remained symptomatic for demodex blepharitis after an adequate trial of **ONE** of the following: topical tea tree oil **OR** an eye lid hygiene regimen such as lid scrubbing wipes or debridement? ❑Yes ❑No
7. Is Xdemvy being prescribed by or in consultation with an optometrist, ophthalmologist, dermatologist, or a specialist in the treatment of the patient's diagnosis? ❑Yes ❑No