



Federal Employee Program.

**XELSTRYM  
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: <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:	R <input type="text"/>			Physician Signature:		
<b>PHYSICIAN COMPLETES</b>						

**Xelstrym (dextroamphetamine)**

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

**Please select patch strength and provide quantity:**

<input type="checkbox"/> 4.5 mg/9 hours	quantity _____ per day	<input type="checkbox"/> 13.5 mg/9 hours	quantity _____ per day
<input type="checkbox"/> 9 mg/9 hours	quantity _____ per day	<input type="checkbox"/> 18 mg/9 hours	quantity _____ per day

**\*\*Check [www.fepblue.org/formulary](http://www.fepblue.org/formulary) to confirm which medication is part of the patient's benefit**

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

What is the patient's total daily dose (mg/day) of Xelstrym? \_\_\_\_\_ mg/day

1. What is the patient's diagnosis?

☐ Attention Deficit Disorder (ADD)

☐ Attention Deficit Hyperactivity Disorder (ADHD)

☐ Depressive disorder

a. Will Xelstrym be used in combination with antidepressants? ☐ Yes ☐ No\*

**\*If NO**, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to antidepressants? ☐ Yes ☐ No

☐ Narcolepsy

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



**BlueCross  
BlueShield**

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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**

