



Federal Employee Program.

**XHANCE
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:		
PHYSICIAN COMPLETES						

**Xhance nasal spray
(fluticasone propionate)**

****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**

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

Will the patient need more than 6 bottles for a 90 day supply? ☐ Yes* ☐ No

***If YES**, please specify the requested quantity: _____ bottles for a 90 day supply

1. Does the patient have a diagnosis of chronic rhinosinusitis? ☐ Yes ☐ No
2. Has the patient had recent nasal ulcerations, nasal surgery, or nasal trauma? ☐ Yes ☐ No
3. Does the prescriber agree to monitor the patient for changes in vision and for increased intraocular pressure? ☐ Yes ☐ No
4. Does the prescriber agree to monitor the patient for systemic corticosteroid effects such as hypercorticism and adrenal suppression, including adrenal crisis? ☐ Yes ☐ No
5. Has the patient been on Xhance continuously for the last **2 months, excluding samples**? ☐ Yes ☐ No*
***If NO**, please answer the following questions:
 - a. Is Xhance being prescribed or recommended by an Ear, Nose, and Throat (ENT) specialist or an allergist? ☐ Yes ☐ No
 - b. Has the patient had an inadequate treatment response to at least **TWO** of the following corticosteroid nasal sprays for a combined duration of at least three months: mometasone, fluticasone, budesonide, or triamcinolone? ☐ Yes ☐ No



**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:

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. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u>

faster... easier... better...	Introducing ePA! Online Prior Authorizations in minutes through Caremark.com/ePA . Sign up today!
	CVS/caremark 