BlueCross BlueShield
Federal Employee Program

ZYCLARA
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					

Zyclara (imiquimod)

***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

Please select strength/formulation and provide quantity:

❑2.5% pump	**Will the patient need more than 2 bottles for 90 days? ❑Yes* ❑No** ***If YES*, please specify the requested quantity: _____ bottles for 90 days**
❑3.75% packet	**Will the patient need more than 56 packets for 90 days? ❑Yes* ❑No** ***If YES*, please specify the requested quantity: _____ packets for 90 days**
❑3.75% pump	**Will the patient need more than 2 bottles for 90 days? ❑Yes* ❑No** ***If YES*, please specify the requested quantity: _____ bottles for 90 days**

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

1. Is this **INITIATION** or **CONTINUATION** of Zyclara therapy? ***Please select answer below:***

❑**INITIATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Actinic keratosis (AK)

i. Is the patient immunocompromised? ❑Yes ❑No

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to TWO of the following: generic Imiquimod, Fluorouracil, and/or Diclofenac? ❑Yes ❑No

❑External genital and perianal warts (EGW)

i. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to TWO of the following: Podofilox, generic imiquimod, and/or cryotherapy? ❑Yes ❑No

❑None of the above

❑**CONTINUATION** of therapy **(PA renewal)**, please answer the following questions:

a. What is the patient's diagnosis?

❑Actinic keratosis (AK)

i. Has the patient's lesion(s) been re-evaluated for improvement? ❑Yes ❑No

❑External genital and perianal warts (EGW)

i. Has the patient's warts been re-evaluated for improvement? ❑Yes ❑No

❑None of the above

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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. ***Please only fax the completed form once as duplicate submissions may delay processing times.***