BlueCross BlueShield Federal Employee Program

CIMZIA
PRIOR APPROVAL REQUEST

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.

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: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard and Basic Option patients Actemra SC, Enbrel, Humira including preferred Humira biosimilars, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, and Xeljanz/ Xeljanz XR are preferred products.
Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Cimzia (certolizumab pegol)

****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. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer questions on **PAGE 4**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No
   If YES, was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*
   If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
4. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
5. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes* ❑ No
   If YES, has HBV infection been ruled out or has the patient already started treatment for HBV infection? ❑Yes ❑No
6. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
7. Will Cimzia be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   ****DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.***
8. What is the patient's diagnosis?
   ❑ Ankylosing spondylitis (AS)
   a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Enbrel, Rinvoq, or Taltz? ❑Yes* ***(*If YES, please select the preferred product below)*** ❑No
      ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Taltz
   b. Does the patient have active ankylosing spondylitis? ❑Yes ❑No
   c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No
   d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 3 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Crohn's disease (CD)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Has the patient tried and failed Humira or a Humira biosimilar? ❑Yes ❑No*

If NO, would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes* ❑No

If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya

b. Does the patient have moderate to severe Crohn's disease? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes ❑No

d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No

❑ Non-radiographic axial spondyloarthritis (nr-axSpA)

a. Does the patient have active non-radiographic axial spondyloarthritis? ❑Yes ❑No

b. Does the patient have objective signs of inflammation? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No

d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No

e. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is Cimzia being requested as a change from Bimzelx or Cosentyx to allow the member access to their copay benefit? ❑Yes* ❑No

If YES, please select medication: ❑Bimzelx ❑Cosentyx

❑ Plaque psoriasis (PsO)

a. **Standard/Basic patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Enbrel, Otezla, Skyrizi, Stelara SC, Talz, or Tremfya? ❑Yes* ***(*If YES, please select the preferred product below)*** ❑No

❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya

b. Does the patient have moderate to severe plaque psoriasis? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ***Please select answer below:***

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried conventional systemic therapy

d. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy?

❑Inadequate response ❑Intolerance or contraindication ❑Patient has not tried phototherapy

e. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every other week? ❑Yes ❑No

❑ Psoriatic arthritis (PsA)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, and Xeljanz/Xeljanz XR? ❑Yes* ❑No

If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya ❑Xeljanz/Xeljanz XR

b. Does the patient have active psoriatic arthritis? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No

PLEASE PROCEED TO <u>PAGE 3</u> FOR ADDITIONAL DIAGNOSES

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PAGE 2 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Polyarticular juvenile idiopathic arthritis (pJIA)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Has the patient tried and failed, Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑**Yes:** Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Actemra SC including preferred Actemra SC biosimilars, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes***** ❑No

If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Actemra SC/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

❑**No**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes***** ❑No

If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

b. Does the patient have active polyarticular juvenile idiopathic arthritis (pJIA)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

d. **Age 2-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 10 kg (22 lbs)**

❑**10 kg (22 lbs) to less than 20 kg (44 lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg every other week? ❑Yes ❑No

❑**20 kg (44 lbs) to less than 40 kg (88 lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 100mg every other week? ❑Yes ❑No

❑**40 kg (88 lbs) or more**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 200mg every other week? ❑Yes ❑No

e. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 200mg every other week? ❑Yes ❑No

❑ Rheumatoid arthritis (RA)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Has the patient tried and failed, Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑**Yes:** Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Actemra SC including preferred Actemra SC biosimilars, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes***** ❑No

If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Actemra SC/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

❑**No**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes***** ❑No

If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

b. Does the patient have moderate to severely active rheumatoid arthritis? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No

❑ Other ***(please specify):*** _____

<u>FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT</u>:
STANDARD AND BASIC OPTION PATIENT REQUESTS REQUIRES <u>PAGE 6</u> TO BE COMPLETED

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Fax: 1-877-378-4727

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

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard and Basic Option patients Actemra SC, Enbrel, Humira including preferred Humira biosimilars, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, and Xeljanz/ Xeljanz XR are preferred products.
Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

CONTINUATION OF THERAPY (PA RENEWAL)

Cimzia (certolizumab pegol)

****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. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑ **NO** – this is **INITIATION** of therapy, please answer questions on **PAGE 1**
   ❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient's condition improved or stabilized with Cimzia? ❑Yes ❑No
4. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
6. Will Cimzia be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.
7. What is the patient's diagnosis?
   ❑ Ankylosing spondylitis (AS)
      a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Enbrel, Rinvoq, or Taltz? ❑Yes* ***(If YES, please select the preferred product below)*** ❑No
      ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Taltz
      b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No
   ❑ Crohn's disease (CD)
      a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit**: Has the patient tried and failed Humira or a Humira biosimilar? ❑Yes ❑No*
      If NO, would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes* ❑No
      If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya
      b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No
   ❑ Non-radiographic axial spondyloarthritis (nr-axSpA)
      a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 5 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

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PAGE 5 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Plaque psoriasis (PsO)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Enbrel, Otezla, Skyrizi, Stelara SC, Talz, or Tremfya? ❑Yes***** ***(*If YES, please select the preferred product below)*** ❑No
❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya

b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every other week? ❑Yes ❑No

❑ Psoriatic arthritis (PsA)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, and Xeljanz/Xeljanz XR? ❑Yes***** ❑No
****If YES***, please select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya ❑Xeljanz/Xeljanz XR

b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No

❑ Polyarticular juvenile idiopathic arthritis (pJIA)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Has the patient tried and failed, Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑**Yes:** Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Actemra SC including preferred Actemra SC biosimilars, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes***** ***(*If YES, please select the preferred product below)*** ❑No
❑Humira/preferred biosimilar ❑Actemra SC/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

❑**No**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes***** ❑No
****If YES***, please select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

b. **Age 2-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 10 kg (22 lbs)**

❑**10 kg (22 lbs) to less than 20 kg (44 lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg every other week? ❑Yes ❑No

❑**20 kg (44 lbs) to less than 40 kg (88 lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 100mg every other week? ❑Yes ❑No

❑**40 kg (88 lbs) or more**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 200mg every other week? ❑Yes ❑No

c. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 200mg every other week? ❑Yes ❑No

❑ Rheumatoid arthritis (RA)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Has the patient tried and failed Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑**Yes:** Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Actemra SC including preferred Actemra SC biosimilars, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes***** ***(*If YES, please select the preferred product below)*** ❑No
❑Humira/preferred biosimilar ❑Actemra SC/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

❑**No**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes***** ❑No
****If YES***, please select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 400mg every 4 weeks? ❑Yes ❑No

❑ Other ***(please specify):*** _____

<u>FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT</u>:
STANDARD AND BASIC OPTION PATIENT REQUESTS REQUIRES <u>PAGE 6</u> TO BE COMPLETED

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PAGE 6 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
STANDARD AND BASIC OPTION PATIENT REQUESTS REQUIRES PAGE 6 TO BE COMPLETED

1. Please select the diagnosis and answer the following questions:

❑**Ankylosing spondylitis (AS) / Plaque psoriasis (PsO) / Polyarticular juvenile idiopathic arthritis (pJIA) / Psoriatic arthritis (PsA) / Rheumatoid arthritis (RA)**

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to **TWO** of the preferred medications?

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.

Please select answer: ❑Yes ❑No*

***If NO,** is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

❑**Crohn's disease (CD)**

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to one of the following preferred medications: Humira or a Humira biosimilar, Rinvoq, Skyrizi, Stelara (SC), or Tremfya?

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.

Please select answer: ❑Yes ❑No*

***If NO,** is there a clinical reason for not trying one of the preferred medications? ❑Yes ❑No