BlueCross BlueShield Federal Employee Program

COSENTYX
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 Cimzia, Enbrel, Humira including preferred Humira biosimilars, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, and Xeljanz are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Cosentyx (secukinumab)

****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 Cosentyx continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
4. 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
5. Will the patient be given live vaccines while on Cosentyx? ❑Yes ❑No
6. Will Cosentyx be used in combination with another biologic *disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARDs: Actemra, Avsola, Cimzia, 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
7. What is the patient's diagnosis?
   ❑Ankylosing spondylitis (AS)
   a. **Age 18 or older**: **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit:** Would you like to switch the patient to a preferred product: Humira including preferred Humira biosimilars, Enbrel, Rinvoq, or Taltz?
   ❑Yes* ❑No
   If YES, please select the preferred product: ❑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 300mg every four weeks? ❑Yes ❑No
   ❑Enthesitis-related arthritis (ERA)
   a. Does the patient have active enthesitis-related arthritis? ❑Yes ❑No
   b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 150mg every four weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

COSENTYX
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

PAGE 2 – PHYSICIAN COMPLETES

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

❑Hidradenitis Suppurativa (HS)

a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 300mg every two weeks? ❑Yes ❑No

❑Non-radiographic axial spondyloarthritis (nr-axSpA)

a. **Age 18 or older**: **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Would you like to switch the patient to a preferred product: Cimzia, Rinvoq, or Taltz? ❑Yes***** ❑No

****If YES,*** please select the preferred product: ❑Cimzia ❑Rinvoq ❑Taltz

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

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

d. 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

e. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 150mg every four weeks? ❑Yes ❑No

❑Plaque psoriasis (PsO)

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

❑**Age 6-11:** ❑Enbrel ❑Otezla ❑Stelara SC ❑Taltz

❑**Age 12-17**: ❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Stelara SC ❑Taltz

❑**Age 18 or older:** ❑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 ❑Patient has not tried conventional 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. **Age 17 or less**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 150mg every four weeks?
❑Yes ❑No

f. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 300mg every four weeks?
❑Yes ❑No

❑Psoriatic arthritis (PsA)

a. **Age 18 or older**: **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Would you like to switch the patient to a preferred product: Humira including preferred Humira biosimilars, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, Xeljanz/Xeljanz XR? ❑Yes***** ***(*If YES, please select the medication below)*** ❑No
❑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 three month trial of at least one conventional DMARD? ❑Yes ❑No

d. **Age 17 or less**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 150mg every four weeks?
❑Yes ❑No

e. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 300mg every four weeks?
❑Yes ❑No

❑Other diagnosis ***(please specify)***: _____

<u>FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT</u>:
REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES <u>PAGE 5</u> TO BE COMPLETED

BlueCross BlueShield Federal Employee Program

COSENTYX
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 Cimzia, Enbrel, Humira including preferred Humira biosimilars, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, and Xeljanz 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)

Cosentyx (secukinumab)

****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 Cosentyx continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient's condition improved or stabilized with Cosentyx? ❑Yes ❑No
4. Will the patient be given live vaccines while on Cosentyx? ❑Yes ❑No
5. Will Cosentyx be used in combination with another biologic *disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? ❑Yes* ❑No
   ****If YES***, please specify medication: _____
   ****DMARDs: Actemra, Avsola, Cimzia, 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***
6. What is the patient's diagnosis?
   ❑Ankylosing spondylitis (AS)
   a. **Age 18 or older**: **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit:** Would you like to switch the patient to a preferred product: Humira including preferred biosimilars, Enbrel, Rinvoq, or Taltz? ❑Yes* ❑No
   ****If YES,*** please select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Taltz
   b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 300mg every four weeks? ❑Yes ❑No
   ❑Enthesitis-related arthritis (ERA)
   a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 150mg every four weeks? ❑Yes ❑No
   ❑Hidradenitis Suppurativa (HS)
   a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 300mg every two weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

COSENTYX
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

PAGE 4 – PHYSICIAN COMPLETES

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

❑Non-radiographic axial spondyloarthritis (nr-axSpA)

a. **Age 18 or older**: **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Would you like to switch the patient to a preferred product: Cimzia, Rinvoq, or Taltz? ❑Yes***** ❑No

If YES, please select the preferred product: ❑Cimzia ❑Rinvoq ❑Taltz

b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 150mg every four weeks? ❑Yes ❑No

❑Plaque psoriasis (PsO)

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

❑**Age 6-11:** ❑Enbrel ❑Otezla ❑Stelara SC ❑Taltz

❑**Age 12-17**: ❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Stelara SC ❑Taltz

❑**Age 18 or older:** ❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya

b. **Age 17 or less**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 150 mg every four weeks? ❑Yes ❑No

c. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 300 mg every four weeks? ❑Yes ❑No

❑Psoriatic arthritis (PsA)

a. **Age 18 or older: Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Would you like to switch the patient to a preferred product: Humira including preferred Humira biosimilars, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, Xeljanz/Xeljanz XR? ❑Yes***** ***(*If YES, please select the medication below)*** ❑No

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

b. **Age 17 or less**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 150 mg every four weeks? ❑Yes ❑No

c. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 300 mg every four weeks? ❑Yes ❑No

❑Other diagnosis ***(please specify):*** _____

<u>FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT</u>:
REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES <u>PAGE 5</u> TO BE COMPLETED

BlueCross BlueShield Federal Employee Program

COSENTYX
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

PAGE 5 – PHYSICIAN COMPLETES

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

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES PAGE 5 TO BE COMPLETED

1. Please select diagnosis and answer the following questions:

❑Ankylosing spondylitis (AS)

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Humira including preferred Humira biosimilars, Enbrel, Rinvoq, or Taltz?

Please select answer: ❑Yes ❑No**

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

❑Non-radiographic axial spondyloarthritis (nr-axSpA)

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Cimzia, Rinvoq, or Taltz?

Please select answer: ❑Yes ❑No**

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

❑Plaque psoriasis (PsO)

a. **Age 11 years or less:** Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to THREE of the following preferred medications: Enbrel, Otezla, Stelara SC, or Taltz?

Please select answer: ❑Yes ❑No**

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

b. **Age 12 to 17 years:** Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to THREE of the following preferred medications: Humira or a Humira biosimilar, Enbrel, Otezla, Stelara SC, or Taltz?

Please select answer: ❑Yes ❑No**

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

c. **Age 18 years or older:** Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to THREE of the following preferred medications: Humira or a Humira biosimilar, Enbrel, Otezla, Skyrizi, Stelara SC, Taltz, or Tremfya?

Please select answer: ❑Yes ❑No**

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

❑Psoriatic arthritis (PsA)

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Humira or a Humira biosimilar, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, or Xeljanz/Xeljanz XR?

Please select answer: ❑Yes ❑No**

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

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.

BlueCross BlueShield
Federal Employee Program

COSENTYX
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

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.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Cosentyx – FEP MD Fax Form Revised 9/6/2024