BlueCross BlueShield Federal Employee Program

EBGLYSS
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					

Ebglyss (lebrikizumab-lbkz)

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

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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

1. Does the patient have a diagnosis of atopic dermatitis (eczema)? ❑Yes ❑No*
   ***If NO,** will the patient need more than 10 pens or syringes for 16 weeks? ❑Yes* ❑No
   ***If YES**, please specify the requested quantity: _____ pens or syringes for 16 weeks
2. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
3. What is the patient's weight? _____ kg **OR** _____ lbs
4. Will this medication be used in combination with another *non-topical Prior Authorization (PA) medication for atopic dermatitis? ❑Yes* ❑No
   ***If YES**, please specify medication: _____
   ***Non-Topical PA Medications: Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Rinvoq (upadactinib)**
5. Has the patient been on this medication continuously for the last **3 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   i. Is the patient's atopic dermatitis (eczema) moderate to severe? ❑Yes ❑No
   ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical calcineurin inhibitor? ❑Yes ❑No
   iii. **Age 12-17**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical corticosteroid such as desonide or hydrocortisone acetate? ❑Yes ❑No
   iv. **Age 18 or older**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a **High** potency topical corticosteroid such as amcinonide, fluocinonide, or halcinonide? ❑Yes ❑No
   v. Will the patient need more than 10 pens or syringes for 16 weeks? ❑Yes* ❑No
   ***If YES**, please specify the requested quantity: _____ pens or syringes for 16 weeks
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   i. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
   ii. Will the patient need more than 3 pens or syringes every 84 days? ❑Yes* ❑No
   ***If YES**, please specify the requested quantity: _____ pens or syringes every 84 days