BlueCross BlueShield Federal Employee Program

ILUMYA
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 Enbrel, Humira including preferred Humira biosimilars, Otezla, Skyrizi, Stelara SC, Taltz, and Tremfya are preferred products. Standard/Basic Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Ilumya (tildrakizumab-asmn)

****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. **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, Otezla, Skyrizi, Stelara SC, Taltz, or Tremfya? ❑Yes***** ***(*If YES, please select the preferred product below)*** ❑No
   ❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya
2. Is this request for brand or generic? ❑Brand ❑Generic
3. 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 the following questions:
   a. Does the patient have a diagnosis of moderate to severe plaque psoriasis (PsO)? ❑Yes ❑No
   b. 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 treatment response ❑Intolerance or contraindication ❑Has not tried conventional systemic therapy
   c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy? ❑Inadequate treatment response ❑Intolerance or contraindication ❑Has not tried phototherapy
   d. 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
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   a. Does the patient have a diagnosis of plaque psoriasis (PsO)? ❑Yes ❑No
   b. Has the patient's condition improved or stabilized with therapy? ❑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 Ilumya be used in combination with any other biologic DMARD or targeted synthetic DMARD? ❑Yes***** ❑No
   ****If YES***, please specify medication: _____
   ****DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, 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. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 100mg every 12 weeks? ❑Yes ❑No

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
STANDARD AND BASIC OPTION PATIENT REQUESTS REQUIRES PAGE 2 TO BE COMPLETED

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. Ilumya – FEP MD Fax Form Revised 10/18/2024

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PAGE 2 – PHYSICIAN COMPLETES

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

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
STANDARD AND BASIC OPTION PATIENT REQUESTS REQUIRES PAGE 2 TO BE COMPLETED

8. 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, Skyrizi, Stelara SC, Taltz, 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 TWO of the preferred medications? ❑Yes ❑No