BlueCross BlueShield Federal Employee Program

KEVZARA
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 including preferred Actemra SC biosimilars, Enbrel, Humira including preferred Humira biosimilars, Rinvoq, 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.

Kevzara (sarilumab)

****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

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

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 3**
   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
2. Will the patient need more than 6 syringes/pens every 84 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ syringes/pens every 84 days
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? ❑Positive* ❑Negative
   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 bacterial, fungal, or TB? ❑Yes ❑No
5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
6. Is there documentation of an ALT level less than 5 times upper limit of normal (ULN)? ❑Yes ❑No
7. Does the prescriber agree to monitor neutrophil and platelet counts prior to initiation and 4 to 8 weeks after the start of therapy and then every 3 months as clinically indicated? ❑Yes ❑No
8. Will Kevzara be used in combination with any other biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify the 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.***
9. What is the patient's diagnosis?
   ❑Polymyalgia rheumatica (PMR)
   a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to corticosteroids? ❑Yes ❑No*
      If NO, is the patient unable to tolerate a corticosteroid taper? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 5 - PHYSICIAN COMPLETES

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

❑ Rheumatoid arthritis (RA)

a. **Standard/Basic Option, <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 switch the patient to a preferred product? ❑Yes***** ❑No

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

❑**No**: Would you like to switch the patient to a preferred product? ❑Yes***** ❑No

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

b. Does the patient have moderate to severe active rheumatoid arthritis (RA)? ❑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. **<u>For claims adjudicated through the pharmacy benefit</u>**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least ONE biologic or targeted synthetic disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

❑ Polyarticular juvenile idiopathic arthritis (pJIA)

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

❑**Yes:** Would you like to switch the patient to a preferred product? ❑Yes***** ❑No

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

❑**No**: Would you like to switch the patient to a preferred product? ❑Yes***** ❑No

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

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. What is the patient's weight? ***Please select answer below:***

❑ Less than 63 kg (138 lbs)

❑ Greater than or equal to 63 kg (138 lbs)

❑ Other **(*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

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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, Rinvoq, 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)

Kevzara (sarilumab)

****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

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

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 the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
2. Will the patient need more than 6 syringes/pens every 84 days? ❑Yes* ❑No
   ****If YES***, please specify the requested quantity: _____ syringes/pens every 84 days
3. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
4. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
5. Is there documentation of an ALT level less than 5 times upper limit of normal (ULN)? ❑Yes ❑No
6. Does the prescriber agree to monitor neutrophil and platelet counts every 3 months as clinically indicated? ❑Yes ❑No
7. Will Kevzara be used in combination with any other biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   ****If YES***, please specify the 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?
   ❑Polymyalgia rheumatica (PMR)
   ❑Rheumatoid arthritis (RA)
   a. **Standard/Basic Option, for claims adjudicated through the pharmacy benefit:** 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 switch the patient to a preferred product? ❑Yes* ❑No
      ****If YES***, select the preferred product: ❑Humira/preferred Humira biosimilar ❑Enbrel ❑Rinvoq ❑Actemra SC/preferred Actemra SC biosimilar ❑Xeljanz/Xeljanz XR
      ❑**No**: Would you like to switch the patient to a preferred product? ❑Yes* ❑No
      ****If YES***, select the preferred product: ❑Humira/preferred Humira biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

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PAGE 5 - PHYSICIAN COMPLETES

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

❑ Polyarticular juvenile idiopathic arthritis (pJIA)

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

❑**Yes:** Would you like to switch the patient to a preferred product? ❑Yes***** ❑No

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

❑**No**: Would you like to switch the patient to a preferred product? ❑Yes***** ❑No

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

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

❑ Less than 63 kg (138 lbs)

❑ Greater than or equal to 63 kg (138 lbs)

❑ Other **(*please specify*)**: _____

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

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

❑ **Rheumatoid Arthritis (RA)**

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, Actemra SC including preferred Actemra SC biosimilars, Enbrel, Rinvoq, and Xeljanz/Xeljanz XR?

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

❑**Polyarticular juvenile idiopathic arthritis (pJIA)**

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, Actemra SC including preferred Actemra SC biosimilars, Enbrel, Rinvoq, and Xeljanz/Xeljanz XR?

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