

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

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.

r	auent mitorina	ation (required)		1 i ovide	r imormation (requireu)	
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	1 1	1 1		Physician Signature:			
		P	HYSICIAN	COMPLETES			
For Standard and Basic Option patients Actemra SC including preferred Actemra SC biosimilars, 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. Orencia (abatacept) **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							
	ication be given l request)? <i>Please</i>			st) or by subcutaneous (S	C, subQ, SQ, or su	bcut) injection	
□IV infusion	\square NO – this is I	NITIATION of t	therapy, please	ously for the last 6 months answer the questions on P	PAGES 2-3		
□YES – this is a PA renewal for CONTINUATION of therapy, please answer the questions on <u>PAGE 4</u> □SC injection: Has the patient been on this medication continuously for the last 6 months excluding samples? Select answer below:							

□NO – this is **INITIATION** of therapy, please answer questions on **PAGES 5-6**

□YES – this is a PA renewal for CONTINUATION of therapy, please answer questions on PAGES 7-8

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
SUBCUTANEOUS INJECTION REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS
REQUIRES PAGE 9 TO BE COMPLETED

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Date:			Provider Information (required) Provider Name:				
Pa	tient Name:			Specialty:	NPI:		
Date of Birth: Sex: ☐Male ☐Female		Office Phone:	Office Fax:				
Str	reet Address:			Office Street Address:			
Cit	ty:	State:	Zip:	City:	State:	Zip:	
Pat	tient ID:			Physician Signature:		1	
	K L	P	HYSICIAN	COMPLETES			
				OUGH THE PHARMACY BEN			
	lumira biosimilars, Otezla, Rinvo	oq, Skyrizi, Stelara	SC, Taltz, Tre	ferred Actemra SC biosimilars, I mfya, and Xeljanz/ Xeljanz XR a le for 2 copays at no cost in the b	re preferred produ		
		Orer	ncia IV In	fusion (abatacept)			
	**Check v			which medication is part of the patie	ent's benefit		
		NOTE: Form m	ust be complet	ed in its entirety for processing	2		
1. I	Has the patient been on this med	dication continuou	ısly for the last	6 months excluding samples?	Please select ans	wer below:	
	□YES – this is CONTINUAT	10.1		•			
	\square NO – this is INITIATION o		•	stions below:			
	s this request for brand or gene						
3. I	Has the patient had a tuberculin				lNo		
	•	-	-	nfection? □Negative □Posite patient currently receiving trea		lYes □No	
4. I	s the patient at risk for hepatitis	_			_		
	•			lready started treatment for HB	V infection? □Y	es 🗆 No	
5. I	Does the patient have any active	e infections includ	ing tuberculos	is (TB) and hepatitis B virus (H	BV)? □Yes □	lNo	
6. V	Will the patient be given live va	accines while on O	rencia? Yes	s \square No			
		ation with another No	biologic *dis	ease-modifying anti-rheumatic	drug (DMARD) o	or targeted	
	*If YES, please specify medi						
	Ilumya, Inflectra, Kevzara, K	ineret, Olumiant, O	rencia, Otezla,	, Cimzia, Cosentyx, Enbrel, Entyv Remicade, Renflexis, Riabni, Rinv Tremfya, Truxima, Xeljanz/Xeljan	oq, Rituxan, Ruxio	ımira biosimilar, ence, Siliq,	
	What is the patient's diagnosis?						
[□Prophylaxis of acute Graft Ve			1 (VG CTT) 6			
	a. Will the patient be under unrelated-donor? □Yes		etic stem cell tr	ransplantation (HSCT) from a m	natched or 1 allele	-mismatched	
	b. What is the patient's age						
	■ Age 2-5: Does the pres -1), then 12mg/kg on I			DA labeled dose of 15mg/kg or ntation? □Yes □No	the day before tr	ansplantation (Day	
	□ Age 6 or older: Does the prescriber agree not to exceed the FDA labeled dose of 10mg/kg, with a maximum dose of 1,000mg, on the day before transplantation (Day -1), then Days 5, 14, and 28 after transplantation? □ Yes □ No						
	c. Will Orencia be used in	combination with	a calcineurin i	nhibitor and methotrexate?	Yes □No		
	DI E	A CE DDO CEED	TO DACE 2	EOD ADDITIONAL DIAGN	OGEG		

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

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Federal Employee Program. PRIOR APPROVAL REQUEST

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PAGE 3 - PHYSICIAN COMPLETES

Patient Name:	_ DOB:	Patient ID: R	
□Juvenile Rheumatoid Arthritis (JRA) a. Is the patient's arthritis active? □		ular Juvenile Idiopathic Arthritis (pJIA)	
b. Does the prescriber agree not to ex	ceed the FDA labele	ed maintenance dose of 1000mg every four weeks? Yes	No
c. Does the patient have a contraindic *If NO, does the patient have an least one conventional DMARD	intolerance or have	conventional DMARD? □Yes □No* they had an inadequate treatment response to a three-month tria	al of at
*		n or have they had an inadequate treatment response to biologic o (<u>only applies to claims adjudicated through the pharmacy bene</u>	
☐Psoriatic Arthritis (PsA)			
a. Is the patient's arthritis active? \Box	Yes □No		
b. Does the prescriber agree not to ex	ceed the FDA labele	ed maintenance dose of 1000mg every four weeks?	No
 c. Does the patient have a contraindic *If NO, does the patient have an least one conventional DMARD 	intolerance or have	conventional DMARD? □Yes □No* they had an inadequate treatment response to a three-month tria	al of at
*		n or have they had an inadequate treatment response to biologic o (only applies to claims adjudicated through the pharmacy ben	
□Rheumatoid Arthritis (RA)			
a. Does the patient have moderate to	severely active rheu	matoid arthritis? \(\textstyre{	
b. Does the prescriber agree not to ex	ceed the FDA labele	ed maintenance dose of 1000mg every four weeks? □Yes □	No
 c. Does the patient have a contraindic *If NO, does the patient have an least one conventional DMARD 	intolerance or have	conventional DMARD? □Yes □No* they had an inadequate treatment response to a three-month tria	al of at
DMARD or targeted synthetic DM	ARD? □Yes □N	n or have they had an inadequate treatment response to biologic to (only applies to claims adjudicated through the pharmacy benefits	
☐Other diagnosis (please specify):			

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PRIOR APPROVAL REQUEST

Federal Employee Program. 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** Eav. 1-877-378-4727

Patient Info	mation (required)		Provider In	formation (requ	uired)			
Date:	_		Provider Name:	_				
Patient Name:			Specialty:	NPI:				
Date of Birth:	Sex: □Male	□Female	Office Phone:	Office Fax:				
Street Address:			Office Street Address:	I				
City:	State:	Zip:	City:	State:	Zip:			
Patient ID: R I I	1 1 1	1 1	Physician Signature:					
	I	PHYSICIAN	COMPLETES					
For Standard and Basic Option Humira biosimilars, Otezla, R	n patients Actemra S invoq, Skyrizi, Stelara	C including pro a SC, Taltz, Tre	ROUGH THE PHARMACY BEN eferred Actemra SC biosimilars, I emfya, and Xeljanz/ Xeljanz XR a ble for 2 copays at no cost in the b	Enbrel, Humira inc re preferred produ				
C	ONTINUATIO	ON OF TH	HERAPY (PA RENEV	WAL)				
			fusion (abatacept)					
**Che			n which medication is part of the pation					
	NOTE: Form n	nust be comple	ted in its entirety for processing	7				
 Has the patient been on this □NO – this is INITIATIO □YES – this is CONTINU. 	N of therapy, please	answer the que		Please select ansv	ver below:			
2. Is this request for brand or g	eneric? □Brand □	Generic						
3. What is the patient's diagnosis? □Juvenile Rheumatoid Arthritis (JRA) □Polyarticular Juvenile Idiopathic Arthritis (pJIA) □Psoriatic Arthritis (PsA) □Rheumatoid Arthritis (RA)								
☐Other diagnosis (please sp	pecify):							
4. Does the prescriber agree no	t to exceed the FDA	labeled mainte	enance dose of 1000mg every fo	ur weeks? □Yes	□No			
5. Has the patient's condition improved or stabilized with Orencia? □Yes □No								
6. Does the patient have any ac	6. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? □Yes □No							
7. Will the patient be given live	e vaccines while on (Orencia? □Ye	s 🗖No					
8. Will Orencia be used in combination with another biologic *disease-modifying anti-rheumatic drug (DMARD) or targeted synthetic DMARD? **If YES, please specify:								

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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.



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Applete the patient portion, and have the prescribing physician complete the

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Patient Information (required)			Provider Information (required)					
Date:			Provider Name:					
Patient Name:			Specialty:		NPI:			
Date of Birth:	ate of Birth: Sex: Male Female				Office Fax:			
Street Address:	l		Office Street Address:					
City:	State:	Zip:	City:	Sta	te:	Zip:		
Patient ID: R	1 1 1		Physician Signature:	L		1		
PHYSICIAN COMPLETES								
For Standard and Basic Option particles Humira biosimilars, Otezla, Rinvo	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, 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.							
	Orencia		ous Injection (SO	C)				
**Check v	www.fenblue.org/forn	(abata) nulary to confirm	cept) which medication is part of t	he natient's	henefit			
Circu	-	•	ed in its entirety for proc	•	benem			
1. Has the patient been on this med □YES – this is CONTINUATION	lication continuou	sly for the last (6 months excluding sam		se select ansv	ver below:		
\square NO – this is INITIATION of		-	ons below:					
2. Is this request for brand or gene		Generic						
3. What is the patient's diagnosis? □Juvenile rheumatoid arthritis a. Standard/Basic Option Humira or a Humira bios	s (JRA) <u>OR</u> patient, <u>for clain</u> similar, Enbrel, Ri	ns adjudicated nvoq, or Xeljan	nz? Please select answer	benefit: I below:	Has the patier			
□Yes: Would you like to participate in this program and switch the patient to one of the preferred medications? □Yes* □No *If YES, select the preferred medication: □Humira/preferred biosimilar □Actemra SC/preferred biosimilar □Enbrel □Rinvoq □Xeljanz								
□No: Would you like to participate in this program and switch the patient to one of the preferred medications? □Yes* □No *If YES, select the preferred medication: □Humira/preferred biosimilar □Enbrel □Rinvoq □Xeljanz								
b. Is the patient's arthritis a	active? □Yes □	■No						
□ Psoriatic arthritis (PsA) 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? □ Yes* (*If YES, select the preferred product below) □ No □ Humira/preferred biosimilar □ Enbrel □ Otezla □ Rinvoq □ Skyrizi □ Stelara SC □ Taltz □ Tremfya □ Xeljanz/Xeljanz XR								
b. Does the patient have active psoriatic arthritis (PsA)? \(\textstyle \te								
□Rheumatoid arthritis (RA) a. Standard/Basic Option Humira or a Humira bio	n patient, <u>for clai</u> osimilar, Enbrel, R	ims adjudicated Linvoq, or Xelja	d through the pharmac nz/Xeljanz XR? <i>Please</i> s	select answ	ver below			
If YES, sele	□Yes: Would you like to participate in this program and switch the patient to one of the preferred products? □Yes □No *If YES, select the preferred product: □Humira/preferred biosimilar □Actemra SC/preferred biosimilar □Enbrel □Rinvoq □Xeljanz/Xeljanz XR							
			itch the patient to one of the ra/preferred biosimilar					
b. Does the patient have n	noderate to severe	ly active rheum	atoid arthritis (RA)?	Yes □N	0			
☐Other (please specify):								

PLEASE PROCEED TO PAGE 6 FOR ADDITIONAL QUESTIONS

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PAGE 6 - PHYSICIAN COMPLETES						
Patient Name:	DOB:	Patient ID: R				
4. Does the prescriber agree not to exce	ed the FDA labeled mainten	ance dose of 125mg every week? □Yes □No				
-	tolerance or have they had an	disease-modifying anti-rheumatic drug (DMARD)? □Yes □No* in inadequate treatment response to a 3 month trial of at least one and a second of the second of t				
6. Has the patient had a tuberculin skin *If YES, was the result of the test p *If POSITIVE, has the patient co	ositive or negative for TB in					
7. Is the patient at risk for hepatitis B vi **If YES*, has hepatitis B virus (HBV infection? □Yes □No		s* □No r has the patient already started treatment for HBV				
8. Does the patient have any active infe	ctions including tuberculosis	s and hepatitis B virus (HBV)? \(\sigma\)Yes \(\sigma\)No				
9. Will the patient be given live vaccine	es while on this therapy?	Yes □No				
*If YES, please specify medication *DMARDs: Actemra or an Actemra Ilumya, Inflectra, Kevzara, Kineret,	: biosimilar, Avsola, Bimzelx, C Olumiant, Orencia, Otezla, Re	AARD or targeted synthetic DMARD? Yes* No Simzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, micade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, emfya, Truxima, Xelianz/Xelianz XR, Zymfentra.				

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
SUBCUTANEOUS INJECTION REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS
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Date:		Atton (required)			Provider In Provider Name:	1101		quireu)
Patient Name:					Specialty:		NPI:	
Date of Birth: Sex: □Male □Female				Office Phone:		Office Fax:		
Street Address:					Office Street Address:			
City:		State:	Zip:		City:	State	e:	Zip:
Patient ID: R	<u> </u>	1 1	<u> </u>		Physician Signature:			
		P	PHYSICIA	N C	COMPLETES			
	ic Option pa tezla, Rinvo switch to	atients Actemra S q, Skyrizi, Stelara a preferred produ TINUATIO	C including p a SC, Taltz, T act will be elig	refe rem gible	erred Actemra SC biosimilars, F fya, and Xeljanz/ Xeljanz XR at for 2 copays at no cost in the be ERAPY (PA RENEV	Enbre re pro enefit	l, Humira inc eferred produ year.	
		Orencia			ous Injection (SC)			
	**Check w		mulary to confi	irm v	cept) which medication is part of the pation d in its entirety for processing		enefit	
□NO – this is INITI □YES – this is a PA 2. Is this request for brack 3. What is the patient's a □Juvenile rheumator a. Standard/Base Humira or a H □Yes: Would y *If Y □Psoriatic arthritis (I a. Standard/Base program and sy	renewal for renewal for renewal for dor general diagnosis? Id arthritis (sic Option fumira bios you like to payes, select for our like to payes, select for option payes, witch the page ferred biosi	f therapy, please a for CONTINUAT ric? □Brand □ (JRA) OR patient, for claim imilar, Enbrel, R participate in this a the preferred meaning the the preferred meaning the preferr	answer the quantum of the radication: adjudication: adjudication: adjudication: adjudication: adjudicated preferred pro	lar j lar j ljan: swit Hum Enbr Hum	please answer the following of the particle idiopathic arthritis (pJ through the pharmacy beneficially Please select answer below the patient to one of the preferring/preferred biosimilar \(\textstyle \text{Ac}\)	IIA) fit: H erred temred thorel	as the patien medications? a SC/preferre medications? □Rinvoq you like to p	at tried and failed Yes* No ed biosimilar Yes* No Xeljanz Participate in this elow) No
□Rheumatoid arthrit a. Standard/Ba Humira or a I □Yes: Would *If □No: Would *If Y	is (RA) asic Option Humira bio I you like to YYES, select you like to	similar, Enbrel, I participate in this of the preferred preferred participate in this the preferred produced	Rinvoq, or Xos program and roduct: □Hu □En program and	eljand sw mira brel swi	I through the pharmacy bender a large select of the patient to one of the present a large select of the present of the patient to one of the present of the patient to one of the present of the patient to one of the present of the present of the patient of the	answ ferred mra S janz S	er below: d products? [SC/preferred XR products? [□Yes* □No biosimilar □Yes* □No

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PAGE 8 - PHYSICIAN COMPLETES

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Patient Name:	DOB:	Patient ID: R
4. Does the prescriber agree not to excee	ed the FDA labeled maintenance	dose of 125mg every week? □Yes □No
5. Has the patient's condition improved	or stabilized with therapy?	es □No
6. Does the patient have any active infec	ctions including tuberculosis and	hepatitis B virus (HBV)? □Yes □No
7. Will the patient be given live vaccines	s while on this therapy? □Yes	□No
8. Will Orencia be used in combination ************************************	· ·	or targeted synthetic DMARD? □Yes* □No
Ilumya, Inflectra, Kevzara, Kineret,	Olumiant, Orencia, Otezla, Remic	ia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, ade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, sva. Truxima. Xelianz/Xelianz XR. Zvmfentra.

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1.

BlueShield. ORENCIA Federal Employee Program. PRIOR APPROVAL REQUEST

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PAGE 9 - PHYSICIAN COMPLETES							
Patient Name:	DOB:	Patient ID: R					
<u>FOR CLAI</u> SUBCUTANEOUS INJ	MS ADJUDICATED THRO IECTION REQUESTS FOI REQUIRES <u>PAGE 9</u> T	OUGH THE PHARMACY BENE R STANDARD AND BASIC OPT TO BE COMPLETED	<u>EFIT:</u> ION PATIENTS				
. Please select the diagnosis and answ	wer the following questions:						
□Juvenile rheumatoid arthritis (JRA)/Polyarticular juvenile	e idiopathic arthritis (pJIA)					
	ications: Humira or a Humira	* or have they had an inadequate tre biosimilar, Actemra SC or an Acte					
*If NO, is there a clinical 1	reason for not trying TWO of	the preferred medications? •Yes	□No				
☐Rheumatoid arthritis (RA)							
 a. Does the patient have an into the following preferred meding Rinvoq, or Xeljanz/Xeljanz 	ications: Humira or a Humira	* or have they had an inadequate tre biosimilar, Actemra SC or an Acte	eatment response to TWO of mra SC biosimilar, Enbrel,				
*If NO, is there a clinical 1	reason for not trying TWO of	the preferred medications? •Yes	□No				
□Psoriatic arthritis (PsA)							
 a. Does the patient have an into the following preferred medians Tremfya, or Xeljanz/Xeljanz 	ications: Humira or a Humira	* or have they had an inadequate tre biosimilar, Enbrel, Otezla, Rinvoq,	eatment response to TWO of Skyrizi, Stelara SC, Taltz,				
*If NO, is there a clinical r	reason for not trying TWO of	the preferred medications? Yes	□No				
		atibody formation/lupus-like syndrome, ting disorder such as multiple sclerosis					

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