BlueCross BlueShield Federal Employee Program.

SILIQ
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. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Siliq (brodalumab)

****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? ❑Yes***** ***(*If YES, 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. Does the patient have a diagnosis of plaque psoriasis (PsO)? ❑Yes ❑No
4. Does the patient have any active infections, including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
5. Does the prescriber agree to monitor for onset or exacerbations of Crohn's disease and to discontinue therapy if necessary? ❑Yes ❑No
6. Does the prescriber agree to participate in Siliq REMS Program and to monitor for onset of suicidal ideation and behavior and discontinue therapy if necessary? ❑Yes ❑No
7. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
8. Will Siliq be used in combination with any other biologic *****DMARD or targeted synthetic DMARD? ❑Yes***** ❑No
   ****If YES***, please specify the medication: _____
   ****DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Rinvoq, Rituxan, Ruxience, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR***
9. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 210 mg every 2 weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

BlueCross BlueShield Federal Employee Program.

SILIQ
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 _____

10. 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 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? ❑ Positive***** ❑ Negative

****If POSITIVE***, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No

e. Does the prescriber agree to re-evaluate the patient's condition at week 12 to 16 to confirm if therapy with Siliq may continue? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Has the patient's condition improved or stabilized on therapy? ❑Yes ❑No

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

1. Does the patient have a history of demyelinating disorder? ❑Yes ❑No

2. Does the patient have a history of congestive heart failure? ❑Yes ❑No

3. Does the patient have a history of Hepatitis B Virus infection? ❑Yes ❑No

4. Does the patient have autoantibody formation/lupus-like syndrome? ❑Yes ❑No

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

❑**Yes:** Please specify the medications and results below:

_____

_____

❑**No:** Is there a clinical reason for not trying **TWO** of the preferred medications: Humira or a Humira biosimilar, Enbrel, Otezla, Skyrizi, Stelara SC, Taltz, or Tremfya? ❑Yes***** ❑No

****If YES***, please describe the clinical reason below:

_____

_____

BlueCross BlueShield Federal Employee Program.

SILIQ
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.***