BlueCross BlueShield
Federal Employee Program

VELSIPITY
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 Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, 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.

Velsipity (etrasimod)

****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. **Standard/Basic Option Patient:** Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes* ❑No
   If YES, please select one of the following: ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara (SC) ❑Tremfya
2. Will the patient need more than 90 tablets every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ tablets every 90 days
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 severely active ulcerative colitis (UC)? ❑Yes ❑No
   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least ONE conventional therapy option? ❑Yes ❑No
   c. Has the prescriber obtained or will the prescriber obtain baseline live function tests (LFTs), complete blood count (CBC) including lymphocyte count, and electrocardiogram (ECG) evaluations prior to starting therapy? ❑Yes ❑No
   d. Does the patient have a history of uveitis and/or diabetes? ❑Yes* ❑No
      If YES, will an ophthalmic evaluation of the fundus, including the macula, be completed prior to initiation of therapy? ❑Yes ❑No
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Does the patient have a diagnosis of ulcerative colitis (UC)? ❑Yes ❑No
   b. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
4. Does the patient have a heart rate greater than or equal to 50 beats per minute? ❑Yes ❑No
5. Does the patient have a history (within the last six months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure? ❑Yes ❑No
6. Does the patient have a presence of Mobitz Type II 2nd degree or 3rd degree AV block, sick sinus syndrome, or sino-atrial block? ❑Yes* ❑No
   If YES, does the patient have a pacemaker? ❑Yes ❑No
7. Does the patient have significant QTc prolongation (QTcF greater than or equal to 450 msec in males, greater than or equal to 470 msec in females)? ❑Yes ❑No
8. Does the patient have severe untreated sleep apnea? ❑Yes ❑No
9. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
10. Will this medication be used in combination with a biologic DMARD or targeted synthetic DMARD for ulcerative colitis (UC) (e.g., Entyvio, Humira, Simponi, Skyrizi, Stelara, Xeljanz)? ❑Yes* ❑No
    If YES, please specify the medication: _____

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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. Velsipity – FEP MD Fax Form Revised 12/6/2024

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PAGE 2 - PHYSICIAN COMPLETES

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

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

11. 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, Rinvoq, Skyrizi, Stelara SC, 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

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