BlueCross BlueShield Federal Employee Program

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

Zymfentra injection (infliximab-dyyb)

****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. Has the patient been on this medication continuously for the last **3 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. Is this request for brand or generic? ❑Brand ❑Generic
3. Will the patient need more than 4 injections every 56 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ injections every 56 days
4. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
5. Will the patient complete an intravenous (IV) induction regimen with an infliximab product before starting Zymfentra? ❑Yes ❑No
6. Has the patient had a tuberculosis (TB) test prior to initiating therapy? ❑Yes* ❑No
   If YES, does the patient have an active or latent tuberculosis infection? ❑Active TB ❑Latent TB* ❑Test was negative
   If LATENT TB, has the patient started treatment for the infection prior to the use of this medication? ❑Yes ❑No
7. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes* ❑ No
   If YES, has HBV infection been ruled out or has the patient already started treatment for HBV infection? ❑Yes ❑No
8. Does the patient have any active infections? ❑Yes ❑No
9. Will this medication be used in combination with any other biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify the medication: _____
   DMARDs: Actemra, 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.
10. What is the patient's diagnosis?
    ❑ Crohn's disease (CD)
    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: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes* ***(*If YES, please select the preferred product below)*** ❑No
       ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya
    b. Does the patient have moderate to severely active Crohn's disease (CD)? ❑Yes ❑No
    c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional therapy for Crohn's disease (CD)? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 3 – PHYSICIAN COMPLETES

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

❑ Ulcerative colitis (UC)

a. **Standard/Basic option patient, <u>for claims adjudicated through the pharmacy benefit</u>**: 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***** ***(*If YES, please select the preferred product below)*** ❑No
❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya

b. Does the patient have moderate to severely active ulcerative colitis (UC)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional therapy for ulcerative colitis (UC)? ❑Yes ❑No

❑ Other ***(please specify):*** _____

<u>FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT</u>:
STANDARD AND BASIC OPTION PATIENT REQUESTS REQUIRES <u>PAGE 4</u> TO BE COMPLETED

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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.
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)

Zymfentra injection (infliximab-dyyb)

****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. Has the patient been on this medication continuously for the last 3 **months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer questions on **PAGE 1**
   ❑**YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Will the patient need more than 4 injections every 56 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ injections every 56 days
4. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
5. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
6. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? ❑Yes ❑No
7. Will this medication be used in combination with any other biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify the medication: _____
   ****DMARDs: Actemra, 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.***
8. What is the patient's diagnosis?
   ❑Crohn's disease (CD)
   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: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes* ***(If YES, please select the preferred product below)*** ❑No
   ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya
   b. Does the patient have moderate to severely active Crohn's disease (CD)? ❑Yes ❑No
   ❑Ulcerative colitis (UC)
   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: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes* ***(If YES, please select the preferred product below)*** ❑No
   ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya
   b. Does the patient have moderate to severely active ulcerative colitis (UC)? ❑Yes ❑No
   ❑Other ***(please specify):*** _____

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
STANDARD AND BASIC OPTION PATIENT REQUESTS REQUIRES PAGE 4 TO BE COMPLETED

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PAGE 5 - PHYSICIAN COMPLETES

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

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
STANDARD AND BASIC OPTION PATIENT REQUESTS REQUIRES PAGE 4 TO BE COMPLETED

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

❑ **Crohn's disease (CD)**

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 or a Humira biosimilar, 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

❑**Ulcerative colitis (UC)**

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 or a Humira biosimilar, 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