BlueCross BlueShield
Federal Employee Program

ADALIMUMAB
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					
All approved requests for HUMIRA OR NON-PREFERRED BIOSIMILARS are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage. SUBMITTING THE PATIENT'S MEDICAL RECORDS IS REQUIRED.					

ADALIMUMAB

NOTE: Form must be completed in its **entirety** for processing

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Please select the requested medication and proceed with answering the questions on the pages indicated below:

❑Hyrimoz **❑adalimumab-adaz (generic Hyrimoz)** **❑(adalimumab-fkjp) (generic Hulio)**

a. 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 **PAGES 2-5**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 6-8**

❑Abrilada (adalimumab)
❑Amjevita (adalimumab-atto)
❑Cyltezo (adalimumab-adbm)
❑Hadlima (adalimumab-bwwd)
❑Hulio (BRAND)
❑Humira (adalimumab)
❑Idacio (adalimumab-aacf)
❑Simlandi (adalimumab-ryvk)
❑Yuflyma (adalimumab-aaty)
❑Yusimry (adalimumab-aqvh)

a. 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 **PAGES 9-20**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 21-32**

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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					

INITIATION OF THERAPY

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑Hyrimoz **❑adalimumab-adaz (generic Hyrimoz)** **❑(adalimumab-fkjp) (generic Hulio)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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 the questions on **PAGE 6**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:

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

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. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes* ❑No
   If YES, has hepatitis B virus (HBV) infection been ruled out or has the patient already started treatment for HBV infection? ❑Yes ❑No

5. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No

6. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No

7. Will this medication be used in combination with another 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 or a Stelara biosimilar, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR.

PLEASE PROCEED TO PAGE 3 FOR DIAGNOSES

BlueCross BlueShield Federal Employee Program

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PAGE 2 - PHYSICIAN COMPLETES

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

8. What is the patient's diagnosis?

❑ Ankylosing spondylitis (AS)

a. Does the patient have active ankylosing spondylitis (AS)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No

c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

d. Is this medication being requested as a change from Bimzelx, Cimzia, Cosentyx, Humira or a non-preferred biosimilar, or Simponi? ❑Yes* ❑No

If YES, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑ Humira or a non-preferred biosimilar ❑Simponi

❑ Crohn's disease (CD)

a. Does the patient have moderately to severely active Crohn's disease (CD)? ❑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. Is this medication being requested as a change from Cimzia, Entyvio, Humira or a non-preferred biosimilar, Omvoh, or Stelara or a non-preferred biosimilar? ❑Yes* ❑No

If YES, please select medication: ❑Cimzia ❑Entyvio ❑ Humira or a non-preferred biosimilar ❑Omvoh ❑Stelara or a non-preferred biosimilar

d. **Age 6-17**: What is the patient's weight? ***Please select answer below:***

❑Less than 17kg (37lbs)

❑17kg (37lbs) to less than 40kg (88lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑Greater than or equal to 40kg (88lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

e. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑ Hidradenitis suppurativa (HS)

a. **Age 12-17**: What is the patient's weight? ***Please select answer below:***

❑Less than 30kg (66lbs)

❑30kg (66lbs) to less than 60kg (132lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑Greater than or equal to 60kg (132lbs): Which dosing is being requested? ***Please select answer below:***

❑40mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑80mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Which dosing is being requested? ***Please select answer below:***

❑40mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑80mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

❑ Psoriatic arthritis (PsA)

a. Does the patient have active psoriatic arthritis (PsA)? ❑Yes ❑No

b. 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 DMARD? ❑Yes ❑No

c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

d. **Age 18 or older:** Is this medication being requested as a change from Bimzelx, Cimzia, Cosentyx, Humira or a non-preferred biosimilar, Orencia, Simponi, or Stelara or a non-preferred biosimilar? ❑Yes* ❑No

If YES, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Humira or a non-preferred biosimilar ❑Orencia ❑Simponi ❑Stelara or a non-preferred biosimilar

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

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PAGE 3 - PHYSICIAN COMPLETES

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

❑ Plaque psoriasis (PsO)

a. Does the patient have chronic 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 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 response ❑Intolerance or contraindication ❑Has not tried phototherapy

d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

e. Is this medication being requested as a change from Bimzelx, Cimzia, Cosentyx, Humira or a non-preferred biosimilar, Ilumya, Siliq, Sotyktu, or Stelara or a non-preferred biosimilar? ❑Yes* ❑No

If YES, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Humira or a non-preferred biosimilar ❑Ilumya ❑Siliq ❑Sotyktu ❑Stelara or a non-preferred biosimilar

❑ Polyarticular juvenile idiopathic arthritis (pJIA)

a. Does the patient have moderately to severely active polyarticular course juvenile idiopathic arthritis (pJIA)? ❑Yes ❑No

b. 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

c. Is this medication being requested as a change from Actemra or a non-preferred biosimilar, Cimzia, Humira or a non-preferred biosimilar, Kevzara, or Orencia? ❑Yes* ❑No

If YES, please select medication: ❑Actemra or a non-preferred biosimilar ❑Cimzia ❑Humira or a non-preferred biosimilar ❑Kevzara ❑Orencia

d. **Age 2-17**: What is the patient's weight? ***Please select answer below:***

❑Less than 10kg (22lbs)

❑10kg (22lbs) to less than 15kg (33lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 10mg every other week? ❑Yes ❑No

❑15kg (33lbs) to less than 30kg (66lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑Greater than or equal to 30kg (66lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

e. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑ Uveitis

a. **Age 2-17**: What is the patient's weight? ***Please select answer below:***

❑Less than 10kg (22lbs)

❑10kg (22lbs) to less than 15kg (33lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 10mg every other week? ❑Yes ❑No

❑15kg (33lbs) to less than 30kg (66lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑Greater than or equal to 30kg (66lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

PLEASE PROCEED TO PAGE 5 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

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PAGE 4 - PHYSICIAN COMPLETES

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

❑ Rheumatoid arthritis (RA)

a. Does the patient have moderate to severely active rheumatoid arthritis (RA)? ❑Yes ❑No

b. 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

c. Is this medication being requested as a change from Actemra or a non-preferred biosimilar, Cimzia, Humira or a non-preferred biosimilar, Kevzara, Kineret, Olumiant, Orencia , or Simponi? ❑Yes* ❑No

If YES, please select medication: ❑Actemra or a non-preferred biosimilar ❑Cimzia ❑Kevzara ❑Kineret ❑Humira or a non-preferred biosimilar ❑Olumiant ❑Orencia ❑Simponi

d. Will the patient be receiving concurrent therapy with methotrexate (MTX)? ***Please select answer below:***

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**No**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

❑ Ulcerative colitis (UC)

a. 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

b. Is this medication being requested as a change from Entyvio, Humira or a non-preferred biosimilar, Omvoh, Simponi, Stelara or a non-preferred biosimilar, Velsipity, or Zeposia? ❑Yes* ❑No

If YES, please select medication: ❑Entyvio ❑Humira or a non-preferred biosimilar ❑Omvoh ❑Simponi ❑Stelara or a non-preferred biosimilar ❑Velsipity ❑Zeposia

c. **Age 5-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 20kg (44lbs)**

❑**20kg (44lbs) to less than 40kg (88lbs)**: Which dosing is being requested? ***Please select answer below:***

❑**20mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every week? ❑Yes ❑No

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**Greater than or equal to 40kg (88lbs)**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

d. **Age 18 or older**: Was the patient a pediatric patient who has since turned 18 years of age and is well controlled on the recommended pediatric dosage? ***Please select answer below:***

❑**Yes**: Which dosing is being requested? ***Please select strength and answer the following question:***

❑**20mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every week? ❑Yes ❑No

❑**40mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

❑**No**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑ Other ***(please specify)***: _____

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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					

CONTINUATION OF THERAPY (PA RENEWAL)

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑Hyrimoz **❑adalimumab-adaz (generic Hyrimoz)** **❑(adalimumab-fkjp) (generic Hulio)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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 questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
4. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
6. Will this medication be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   ****If YES***, please specify 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 or a Stelara biosimilar, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR.***
7. What is the patient's diagnosis?
   ❑Ankylosing spondylitis (AS)
   a. Is this medication being requested as a change from Bimzelx, Cimzia, Cosentyx, Humira or a non-preferred biosimilar, or Simponi? ❑Yes* ❑No
   ****If YES***, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑ Humira or a non-preferred biosimilar ❑Simponi
   b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No
   ❑Plaque psoriasis (PsO)
   a. Is this medication being requested as a change from Bimzelx, Cimzia, Cosentyx, Humira or a non-preferred biosimilar, Ilumya, Siliq, Sotyktu, or Stelara or a non-preferred biosimilar? ❑Yes* ❑No
   ****If YES***, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Humira or a non-preferred biosimilar ❑Ilumya ❑Siliq ❑Sotyktu ❑Stelara or a non-preferred biosimilar
   b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No
   ❑Psoriatic arthritis (PsA)
   a. **Age 18 or older:** Is this medication being requested as a change from Bimzelx, Cimzia, Cosentyx, Humira or a non-preferred biosimilar, Orencia, Simponi, or Stelara or a non-preferred biosimilar? ❑Yes* ❑No
   ****If YES***, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Humira or a non-preferred biosimilar ❑Orencia ❑Simponi ❑Stelara or a non-preferred biosimilar
   b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

PLEASE PROCEED TO PAGE 7 FOR ADDITIONAL DIAGNOSES

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PAGE 7 - PHYSICIAN COMPLETES

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

❑Crohn's disease (CD)

a. Is this medication being requested as a change from Cimzia, Entyvio, Humira or a non-preferred biosimilar, Omvoh, or Stelara or a non-preferred biosimilar? ❑Yes* ❑No

If YES, please select medication: ❑Cimzia ❑Entyvio ❑ Humira or a non-preferred biosimilar ❑Omvoh ❑Stelara or a non-preferred biosimilar

b. **Age 6-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 17kg (37lbs)**

❑**17kg (37lbs) to less than 40kg (88lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑**Greater than or equal to 40kg (88lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

c. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑Hidradenitis suppurativa (HS)

a. **Age 12-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 30kg (66lbs)**

❑**30kg (66lbs) to less than 60kg (132lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**Greater than or equal to 60kg (132lbs):** Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

❑Polyarticular juvenile idiopathic arthritis (pJIA)

a. Is this medication being requested as a change from Actemra or a non-preferred biosimilar, Cimzia, Humira or a non-preferred biosimilar, Kevzara, or Orencia? ❑Yes* ❑No

If YES, please select medication: ❑Actemra or a non-preferred biosimilar ❑Cimzia ❑Humira or a non-preferred biosimilar ❑Kevzara ❑Orencia

b. **Age 2-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 10kg (22lbs)**

❑**10kg (22lbs) to less than 15kg (33lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 10mg every other week? ❑Yes ❑No

❑**15kg (33lbs) to less than 30kg (66lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑**Greater than or equal to 30kg (66lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

c. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

PLEASE PROCEED TO PAGE 8 FOR ADDITIONAL DIAGNOSES

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PAGE 8 - PHYSICIAN COMPLETES

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

❑Rheumatoid arthritis (RA)

a. Is this medication being requested as a change from Actemra or a non-preferred biosimilar, Cimzia, Humira or a non-preferred biosimilar, Kevzara, Kineret, Olumiant, Orencia , or Simponi? ❑Yes* ❑No

If YES, please select medication: ❑Actemra or a non-preferred biosimilar ❑Cimzia ❑Kevzara ❑Kineret ❑Humira or a non-preferred biosimilar ❑Olumiant ❑Orencia ❑Simponi

b. Will the patient be receiving concurrent therapy with methotrexate (MTX)? ***Please select answer below:***

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**No**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

❑Ulcerative colitis (UC)

a. Is this medication being requested as a change from Entyvio, Humira or a non-preferred biosimilar, Omvoh, Simponi, Stelara or a non-preferred biosimilar, Velsipity, or Zeposia? ❑Yes* ❑No

If YES, please select medication: ❑Entyvio ❑Humira or a non-preferred biosimilar ❑Omvoh ❑Simponi ❑Stelara or a non-preferred biosimilar ❑Velsipity ❑Zeposia

b. **Age 5-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 20kg (44lbs)**

❑**20kg (44lbs) to less than 40kg (88lbs)**: Which dosing is being requested? ***Please select answer below:***

❑**20mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every week? ❑Yes ❑No

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**Greater than or equal to 40kg (88lbs)**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

c. **Age 18 or older**: Was the patient a pediatric patient who has since turned 18 years of age and is well controlled on the recommended pediatric dosage? ***Please select answer below:***

❑**Yes**: Which dosing is being requested? ***Please select strength and answer the following question:***

❑**20mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every week? ❑Yes ❑No

❑**40mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

❑**No**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑Uveitis

a. **Age 2-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 10kg (22lbs)**

❑**10kg (22lbs) to less than 15kg (33lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 10mg every other week? ❑Yes ❑No

❑**15kg (33lbs) to less than 30kg (66lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑**Greater than or equal to 30kg (66lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑Other ***(please specify)***: _____

BlueCross BlueShield Federal Employee Program

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Prior Approval
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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

All approved requests for HUMIRA OR NON-PREFERRED BIOSIMILARS are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage. SUBMITTING THE PATIENT'S MEDICAL RECORDS IS REQUIRED.

INITIATION OF THERAPY

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Abrilada (adalimumab)**
❑**Amjevita (adalimumab-atto)**
❑**Cyltezo (adalimumab-adbm)**
❑**Hadlima (adalimumab-bwwd)**
❑**Hulio (BRAND)**
❑**Humira (adalimumab)**
❑**Idacio (adalimumab-aacf)**
❑**Simlandi (adalimumab-ryvk)**
❑**Yuflyma (adalimumab-aaty)**
❑**Yusimry (adalimumab-aqvh)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).

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 the questions on **PAGE 6**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:

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

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. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes* ❑No
   ****If YES***, has hepatitis B virus (HBV) infection been ruled out or has the patient already started treatment for HBV infection? ❑Yes ❑No

5. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No

6. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No

7. Will this medication be used in combination with another 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 or a Stelara biosimilar, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR.***

PLEASE PROCEED TO PAGE 10 FOR DIAGNOSES

BlueCross BlueShield Federal Employee Program

ADALIMUMAB
PRIOR APPROVAL REQUEST

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Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 2 - PHYSICIAN COMPLETES

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

8. What is the patient's diagnosis? **DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).**

❑Ankylosing spondylitis (AS), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. Does the patient have active ankylosing spondylitis (AS)? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

d. **Standard/Basic Option Patient:** Has the patient tried and failed Enbrel, Rinvoq, Taltz, Xeljanz/Xeljanz XR, generic Hulio (adalimumab-fkjp - Humira biosimilar), or Hyrimoz (Humira biosimilar)? ***Please select answer below:***

❑**YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑**NO – The patient has not tried and failed any of these medications.**

e. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, Rinvoq, Taltz, Xeljanz/Xeljanz XR, generic Hulio (adalimumab-fkjp - Humira biosimilar), and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑**YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Rinvoq ❑Taltz ❑Xeljanz 5 mg ❑Xeljanz XR 11 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑**NO –** Do not switch.

❑**NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑**NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

f. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑**The patient has not tried and failed any formulary alternatives.**

g. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑**YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑**NO –** Do not switch.

PLEASE PROCEED TO PAGE 11 FOR ADDITIONAL DIAGNOSES

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Phoenix, AZ 85072-2080
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PAGE 3 - PHYSICIAN COMPLETES

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

❑Crohn's disease (CD), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. Does the patient have moderately to severely active Crohn's disease (CD)? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

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
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

c. **Age 6-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 17kg (37lbs)**

❑**17kg (37lbs) to less than 40kg (88lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑**Greater than or equal to 40kg (88lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

d. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

e. **Standard/Basic Option Patient:** Has the patient tried and failed Rinvoq, Skyrizi, Tremfya, generic Hulio (adalimumab-fkjp-Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz – Stelara biosimilar) or Yesintek (Stelara biosimilar)? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

f. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Rinvoq, Skyrizi, Tremfya, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar).
Please select answer below:

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Rinvoq ❑Skyrizi ❑Tremfya ❑Hyrimoz ❑generic Hulio (adalimumab-fkjp) ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

g. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

❑ **The patient has not tried and failed any formulary alternatives.**

h. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

PLEASE PROCEED TO PAGE 12 FOR ADDITIONAL DIAGNOSES

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Fax: 1-877-378-4727

PAGE 3 - PHYSICIAN COMPLETES

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

❑Hidradenitis suppurativa (HS), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. **Age 12-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 30kg (66lbs)**

❑**30kg (66lbs) to less than 60kg (132lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**Greater than or equal to 60kg (132lbs):** Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

c. **Standard/Basic Option Patient:** Please answer the following questions:

i. Would you like to switch to a preferred medication? The preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES, switch to generic Hulio (adalimumab-fkjp).**
❑ **YES, switch to Hyrimoz.**
❑ **NO –** Please answer the questions below:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

2) Is there a clinical reason for not trying the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

d. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

e. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

PLEASE PROCEED TO PAGE 13 FOR ADDITIONAL DIAGNOSES

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PAGE 3 - PHYSICIAN COMPLETES

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

❑Psoriatic arthritis (PsA), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. Does the patient have active psoriatic arthritis (PsA)? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

b. 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 DMARD? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

d. **Age 18 or older - Standard/Basic Option Patient:** Has the patient tried and failed Enbrel, generic Hulio (adalimumab-fkjp – Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Rinvoq/LQ, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Taltz, Tremfya, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

e. **Age 18 or older - Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Rinvoq/LQ, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Taltz, Tremfya, and Xeljanz/Xeljanz XR. ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑Rinvoq/LQ ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Skyrizi ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek ❑Xeljanz 5 mg ❑Xeljanz XR 11 mg

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

f. **Age 12 to 17 - Standard/Basic Option Patient:** Please answer the following questions:

i. Would you like to switch to a preferred medication? The preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES, switch to generic Hulio (adalimumab-fkjp).**
❑ **YES, switch to Hyrimoz.**
❑ **NO –** Please answer the questions below:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

2) Is there a clinical reason for not trying the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

PLEASE PROCEED TO PAGE 14 FOR ADDITIONAL PSORIATIC ARTHRITIS RELATED QUESTIONS & OTHER DIAGNOSES

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Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 3 - PHYSICIAN COMPLETES

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

Psoriatic arthritis CONTINUED:

g. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:
❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**
_____

❑ **The patient has not tried and failed any formulary alternatives.**

h. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar).
Please select answer below:

❑ **YES –** Please answer the questions specific to the patient's age below:

i. **Age 18 or older:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. **Age 12 to 17:** Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

iii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑Plaque psoriasis (PsO), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. Does the patient have chronic moderate to severe plaque psoriasis (PsO)? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

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
***Please specify the medical record page number(s). PAGE(s)_____ of _____**

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
***Please specify the medical record page number(s). PAGE(s)_____ of _____**

d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

e. **Age 6 to 11 - Standard/Basic Option Patient:** Please answer the following questions:

i. Would you like to switch to a preferred medication? The preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES, switch to generic Hulio (adalimumab-fkjp).**
❑ **YES, switch to Hyrimoz.**
❑ **NO –** Please answer the questions below:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

2) Is there a clinical reason for not trying the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

PLEASE PROCEED TO PAGE 15 FOR ADDITIONAL PLAQUE PSORIASIS RELATED QUESTIONS & OTHER DIAGNOSES

PAGE 3 - PHYSICIAN COMPLETES

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

Plaque psoriasis CONTINUED:

f. **Age 12 or older - Standard/Basic Option Patient:** Has the patient tried and failed Enbrel, generic Hulio (adalimumab-fkjp – Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), Yesintek (Stelara biosimilar), Taltz, or Tremfya? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

g. **Age 12 or older - Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Taltz, and Tremfya. ***Please select answer below:***

❑ **YES –** Please answer the questions specific to the patient's age below:

i. **Age 18 or older:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Otezla ❑Skyrizi ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. **Age 12 to 17:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Otezla ❑Skyrizi ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

iii. **Age 12 or older:** Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

h. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

i. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), and Otezla. ***Please select answer below:***

❑ **YES –** Please answer the questions specific to the patient's age below:

i. **Age 12 or older:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Otezla

ii. **Age 6 to 11:** Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

iii. **Age 12 or older:** Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

PLEASE PROCEED TO PAGE 16 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

ADALIMUMAB 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 3 - PHYSICIAN COMPLETES

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

❑Polyarticular juvenile idiopathic arthritis (pJIA), **please specify the medical record page number(s) below.**
PAGE(s)_____ of _____

a. Does the patient have moderately to severely active polyarticular course juvenile idiopathic arthritis (pJIA)? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

b. 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
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

c. **Age 2 to 17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 10kg (22lbs)**

❑**10kg (22lbs) to less than 15kg (33lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 10mg every other week? ❑Yes ❑No

❑**15kg (33lbs) to less than 30kg (66lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑**Greater than or equal to 30kg (66lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

d. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

e. **Standard/Basic Option Patient:** Has the patient tried and failed Tyenne (Actemra biosimilar), Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq/LQ, or Xeljanz? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

f. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Tyenne (Actemra biosimilar), Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq/LQ, and Xeljanz. ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Tyenne SC ❑Tyenne IV ❑Enbrel 25mg ❑Enbrel 50mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Rinvoq/LQ ❑ Xeljanz Oral Solution 1mg/mL ❑Xeljanz 5 mg

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

g. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

PLEASE PROCEED TO PAGE 17 FOR ADDITIONAL POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS RELATED QUESTIONS & OTHER DIAGNOSES

BlueCross BlueShield Federal Employee Program

ADALIMUMAB PRIOR APPROVAL REQUEST

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Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 4 - PHYSICIAN COMPLETES

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

Polyarticular juvenile idiopathic arthritis CONTINUED:

h. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Tyenne (Actemra biosimilar), Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), and Hyrimoz (Humira biosimilar).
Please select answer below:

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Tyenne SC ❑Tyenne IV ❑Enbrel 25mg ❑Enbrel 50mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑Uveitis, **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. **Age 2 to 17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 10kg (22lbs)**

❑**10kg (22lbs) to less than 15kg (33lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 10mg every other week? ❑Yes ❑No

❑**15kg (33lbs) to less than 30kg (66lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑**Greater than or equal to 30kg (66lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

c. **Standard/Basic Option Patient:** Please answer the following questions:

i. Would you like to switch to a preferred medication? The preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES, switch to generic Hulio (adalimumab-fkjp).**
❑ **YES, switch to Hyrimoz.**
❑ **NO –** Please answer the questions below:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

2) Is there a clinical reason for not trying the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

d. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

PLEASE PROCEED TO PAGE 18 FOR ADDITIONAL UVEITIS RELATED QUESTIONS & OTHER DIAGNOSES

PAGE 4 - PHYSICIAN COMPLETES

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

Uveitis CONTINUED:

e. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑Rheumatoid arthritis (RA), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. Does the patient have moderate to severely active rheumatoid arthritis (RA)? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

b. 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
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

c. Will the patient be receiving concurrent therapy with methotrexate (MTX)? ***Please select answer below:***

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**No**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

d. **Standard/Basic Option Patient:** Has the patient tried and failed Tyenne (Actemra biosimilar), Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq, or Xeljanz/Xeljanz XR?
Please select answer below:

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

e. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Tyenne (Actemra biosimilar), Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq, and Xeljanz/Xeljanz XR. ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Tyenne SC ❑Tyenne IV ❑Enbrel 25mg ❑Enbrel 50mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Rinvoq ❑ Xeljanz 5mg ❑Xeljanz XR 11mg

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

PLEASE PROCEED TO PAGE 19 FOR ADDITIONAL RHEUMATOID ARTHRITIS RELATED QUESTIONS & OTHER DIAGNOSES

PAGE 4 - PHYSICIAN COMPLETES

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

Rheumatoid arthritis CONTINUED:

f. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:
❑PAGE(s)_____ of _____ Formulary alternative medication(s):_____

_____

❑ The patient has not tried and failed any formulary alternatives.

g. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Tyenne (Actemra biosimilar), Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), and Hyrimoz (Humira biosimilar).
Please select answer below:

❑ YES – Please answer the questions below:

i. Please select the requested preferred medication: ❑Tyenne SC ❑Tyenne IV ❑Enbrel 25mg ❑Enbrel 50mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ NO – Do not switch.

❑Ulcerative colitis (UC), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. 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
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

b. **Age 5 to 17**: What is the patient's weight? ***Please select answer below:***

❑Less than 20kg (44lbs)

❑20kg (44lbs) to less than 40kg (88lbs): Which dosing is being requested? ***Please select answer below:***

❑20mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every week? ❑Yes ❑No

❑40mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑Greater than or equal to 40kg (88lbs): Which dosing is being requested? ***Please select answer below:***

❑40mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑80mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

c. **Age 18 or older**: Was the patient a pediatric patient who has since turned 18 years of age and is well controlled on the recommended pediatric dosage? ***Please select answer below:***

❑Yes: Which dosing is being requested? ***Please select strength and answer the following question:***

❑20mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every week? ❑Yes ❑No

❑40mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑80mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

❑No: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

d. **Standard/Basic Option Patient:** Has the patient tried and failed generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Tremfya, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑ YES –Please specify the medication(s) and medical record page number(s).

Medication(s): _____ PAGE(s)_____ of _____

❑ NO – The patient has not tried and failed any of these medications.

PLEASE PROCEED TO PAGE 20 FOR ADDITIONAL ULCERATIVE COLITIS RELATED QUESTIONS & OTHER DIAGNOSES

BlueCross BlueShield Federal Employee Program

ADALIMUMAB
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.

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P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 4 - PHYSICIAN COMPLETES

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

Ulcerative colitis CONTINUED:

e. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Tremfya, and Xeljanz/Xeljanz XR. ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Rinvoq ❑Skyrizi ❑Tremfya ❑Hyrimoz ❑generic Hulio (adalimumab-fkjp) ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek ❑ Xeljanz 5mg ❑Xeljanz 10mg ❑ Xeljanz XR 11mg ❑Xeljanz XR 22mg

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

f. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

g. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), and Yesintek (Stelara biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ Other ***(please specify)***: _____

BlueCross BlueShield Federal Employee Program

ADALIMUMAB
PRIOR APPROVAL REQUEST

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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

All approved requests for HUMIRA OR NON-PREFERRED BIOSIMILARS are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage. SUBMITTING THE PATIENT'S MEDICAL RECORDS IS REQUIRED.

CONTINUATION OF THERAPY (PA RENEWAL)

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Abrilada (adalimumab)**
❑**Amjevita (adalimumab-atto)**
❑**Cyltezo (adalimumab-adbm)**
❑**Hadlima (adalimumab-bwwd)**
❑**Hulio (BRAND)**
❑**Humira (adalimumab)**
❑**Idacio (adalimumab-aacf)**
❑**Simlandi (adalimumab-ryvk)**
❑**Yuflyma (adalimumab-aaty)**
❑**Yusimry (adalimumab-aqvh)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).

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 questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient's condition improved or stabilized with therapy? ❑Yes* ❑No
   ***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**
4. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
6. Will this medication be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify 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 or a Stelara biosimilar, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR.

PLEASE PROCEED TO PAGE 22 FOR DIAGNOSES

BlueCross BlueShield Federal Employee Program

ADALIMUMAB
PRIOR APPROVAL REQUEST

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Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 2 - PHYSICIAN COMPLETES

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

8. What is the patient's diagnosis? **DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).**

❑Ankylosing spondylitis (AS), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

b. **Standard/Basic Option Patient:** Has the patient tried and failed Enbrel, Rinvoq, Taltz, Xeljanz/Xeljanz XR, generic Hulio (adalimumab-fkjp - Humira biosimilar), or Hyrimoz (Humira biosimilar)? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

c. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, Rinvoq, Taltz, Xeljanz/Xeljanz XR, generic Hulio (adalimumab-fkjp - Humira biosimilar), and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Rinvoq ❑Taltz ❑Xeljanz 5 mg ❑Xeljanz XR 11 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

d. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

e. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

PLEASE PROCEED TO PAGE 23 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

ADALIMUMAB PRIOR APPROVAL REQUEST

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Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 3 - PHYSICIAN COMPLETES

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

❑Crohn's disease (CD), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. **Age 6-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 17kg (37lbs)**

❑**17kg (37lbs) to less than 40kg (88lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑**Greater than or equal to 40kg (88lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

c. **Standard/Basic Option Patient:** Has the patient tried and failed Rinvoq, Skyrizi, Tremfya, generic Hulio (adalimumab-fkjp-Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz – Stelara biosimilar) or Yesintek (Stelara biosimilar)? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

d. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Rinvoq, Skyrizi, Tremfya, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar).
Please select answer below:

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Rinvoq ❑Skyrizi ❑Tremfya ❑Hyrimoz ❑generic Hulio (adalimumab-fkjp) ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

e. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

f. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

PLEASE PROCEED TO PAGE 24 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

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PAGE 3 - PHYSICIAN COMPLETES

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

❑Hidradenitis suppurativa (HS), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. **Age 12-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 30kg (66lbs)**

❑**30kg (66lbs) to less than 60kg (132lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**Greater than or equal to 60kg (132lbs):** Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

c. **Standard/Basic Option Patient:** Please answer the following questions:

i. Would you like to switch to a preferred medication? The preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES, switch to generic Hulio (adalimumab-fkjp).**
❑ **YES, switch to Hyrimoz.**
❑ **NO –** Please answer the questions below:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

2) Is there a clinical reason for not trying the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

d. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

e. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

PLEASE PROCEED TO PAGE 25 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

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PAGE 3 - PHYSICIAN COMPLETES

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

❑Psoriatic arthritis (PsA), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

b. **Age 18 or older - Standard/Basic Option Patient:** Has the patient tried and failed Enbrel, generic Hulio (adalimumab-fkjp – Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Rinvoq/LQ, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Taltz, Tremfya, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

c. **Age 18 or older - Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Rinvoq/LQ, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Taltz, Tremfya, and Xeljanz/Xeljanz XR. ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑Rinvoq/LQ ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Skyrizi ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek ❑Xeljanz 5 mg ❑Xeljanz XR 11 mg

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

d. **Age 12 to 17 - Standard/Basic Option Patient:** Please answer the following questions:

i. Would you like to switch to a preferred medication? The preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES, switch to generic Hulio (adalimumab-fkjp).**
❑ **YES, switch to Hyrimoz.**

❑ **NO –** Please answer the questions below:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

2) Is there a clinical reason for not trying the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

PLEASE PROCEED TO PAGE 26 FOR ADDITIONAL PSORIATIC ARTHRITIS RELATED QUESTIONS & OTHER DIAGNOSES

PAGE 3 - PHYSICIAN COMPLETES

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

Psoriatic arthritis CONTINUED:

e. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:
❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**
_____

❑ **The patient has not tried and failed any formulary alternatives.**

f. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar).
Please select answer below:

❑ **YES –** Please answer the questions specific to the patient's age below:

i. **Age 18 or older:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. **Age 12 to 17:** Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

iii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑Plaque psoriasis (PsO), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

b. **Age 6 to 11 - Standard/Basic Option Patient:** Please answer the following questions:

i. Would you like to switch to a preferred medication? The preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES, switch to generic Hulio (adalimumab-fkjp).**
❑ **YES, switch to Hyrimoz.**
❑ **NO –** Please answer the questions below:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

2) Is there a clinical reason for not trying the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

c. **Age 12 or older - Standard/Basic Option Patient:** Has the patient tried and failed Enbrel, generic Hulio (adalimumab-fkjp – Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), Yesintek (Stelara biosimilar), Taltz, or Tremfya? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

PLEASE PROCEED TO PAGE 27 FOR ADDITIONAL PLAQUE PSORIASIS RELATED QUESTIONS & OTHER DIAGNOSES

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PAGE 3 - PHYSICIAN COMPLETES

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

Plaque psoriasis CONTINUED:

d. **Age 12 or older - Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Taltz, and Tremfya. ***Please select answer below:***

❑ **YES –** Please answer the questions specific to the patient's age below:

i. **Age 18 or older:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Otezla ❑Skyrizi ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. **Age 12 to 17:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Otezla ❑Skyrizi ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

iii. **Age 12 or older:** Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

e. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

f. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), and Otezla. ***Please select answer below:***

❑ **YES –** Please answer the questions specific to the patient's age below:

i. **Age 12 or older:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Otezla

ii. **Age 6 to 11:** Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

iii. **Age 12 or older:** Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

PLEASE PROCEED TO PAGE 28 FOR ADDITIONAL DIAGNOSES

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PAGE 4 - PHYSICIAN COMPLETES

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

❑Polyarticular juvenile idiopathic arthritis (pJIA), **please specify the medical record page number(s) below.**
PAGE(s)_____ of _____

a. **Age 2 to 17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 10kg (22lbs)**

❑**10kg (22lbs) to less than 15kg (33lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 10mg every other week? ❑Yes ❑No

❑**15kg (33lbs) to less than 30kg (66lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑**Greater than or equal to 30kg (66lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

c. **Standard/Basic Option Patient:** Has the patient tried and failed Tyenne (Actemra biosimilar), Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq/LQ, or Xeljanz? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

d. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Tyenne (Actemra biosimilar), Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq/LQ, and Xeljanz. ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Tyenne SC ❑Tyenne IV ❑Enbrel 25mg ❑Enbrel 50mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Rinvoq/LQ ❑ Xeljanz Oral Solution 1mg/mL ❑Xeljanz 5 mg

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

e. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

f. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Tyenne (Actemra biosimilar), Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Tyenne SC ❑Tyenne IV ❑Enbrel 25mg ❑Enbrel 50mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

PLEASE PROCEED TO PAGE 29 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

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PAGE 4 - PHYSICIAN COMPLETES

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

❑Uveitis, **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. **Age 2 to 17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 10kg (22lbs)**

❑**10kg (22lbs) to less than 15kg (33lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 10mg every other week? ❑Yes ❑No

❑**15kg (33lbs) to less than 30kg (66lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑**Greater than or equal to 30kg (66lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

c. **Standard/Basic Option Patient:** Please answer the following questions:

i. Would you like to switch to a preferred medication? The preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES, switch to generic Hulio (adalimumab-fkjp).**
❑ **YES, switch to Hyrimoz.**

❑ **NO –** Please answer the questions below:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

2) Is there a clinical reason for not trying the preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) or Hyrimoz (Humira biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

d. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

e. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications generic Hulio (adalimumab-fkjp - Humira biosimilar) and Hyrimoz (Humira biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

PLEASE PROCEED TO PAGE 30 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

ADALIMUMAB
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 4 - PHYSICIAN COMPLETES

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

❑Rheumatoid arthritis (RA), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. Will the patient be receiving concurrent therapy with methotrexate (MTX)? ***Please select answer below:***

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**No**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

b. **Standard/Basic Option Patient:** Has the patient tried and failed Tyenne (Actemra biosimilar), Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq, or Xeljanz/Xeljanz XR?
Please select answer below:

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

c. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Tyenne (Actemra biosimilar), Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq, and Xeljanz/Xeljanz XR. ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Tyenne SC ❑Tyenne IV ❑Enbrel 25mg ❑Enbrel 50mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Rinvoq ❑ Xeljanz 5mg ❑Xeljanz XR 11mg

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

d. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

e. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Tyenne (Actemra biosimilar), Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), and Hyrimoz (Humira biosimilar).
Please select answer below:

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Tyenne SC ❑Tyenne IV ❑Enbrel 25mg ❑Enbrel 50mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

PLEASE PROCEED TO PAGE 31 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

ADALIMUMAB PRIOR APPROVAL REQUEST

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Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 4 - PHYSICIAN COMPLETES

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

❑Ulcerative colitis (UC), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. **Age 5 to 17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 20kg (44lbs)**

❑**20kg (44lbs) to less than 40kg (88lbs)**: Which dosing is being requested? ***Please select answer below:***

❑**20mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every week? ❑Yes ❑No

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**Greater than or equal to 40kg (88lbs)**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Was the patient a pediatric patient who has since turned 18 years of age and is well controlled on the recommended pediatric dosage? ***Please select answer below:***

❑**Yes**: Which dosing is being requested? ***Please select strength and answer the following question:***

❑**20mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every week? ❑Yes ❑No

❑**40mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

❑**No**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

c. **Standard/Basic Option Patient:** Has the patient tried and failed generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Tremfya, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

d. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Tremfya, and Xeljanz/Xeljanz XR. ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Rinvoq ❑Skyrizi ❑Tremfya ❑Hyrimoz ❑generic Hulio (adalimumab-fkjp) ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek ❑ Xeljanz 5mg ❑Xeljanz 10mg ❑ Xeljanz XR 11mg ❑Xeljanz XR 22mg

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

PLEASE PROCEED TO PAGE 32 FOR ADDITIONAL ULCERATIVE COLITIS RELATED QUESTIONS & OTHER DIAGNOSES

BlueCross BlueShield Federal Employee Program

ADALIMUMAB
PRIOR APPROVAL REQUEST

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Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 4 - PHYSICIAN COMPLETES

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

Ulcerative colitis CONTINUED:

e. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:
❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**
_____

❑ **The patient has not tried and failed any formulary alternatives.**

f. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), and Yesintek (Stelara biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ Other ***(please specify)***: _____