BlueCross BlueShield of North Carolina

Biologic Immunomodulators
Stelara
Prior Authorization (PA) Request Form

To submit request electronically, please go to covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: 888-446-8535

Mail: Blue Cross NC, ATTN: Part D Coverage Determination
P.O. Box 17509, Winston Salem, NC 27116-7509

Call: 888-298-7552 Blue Medicare Rx
888-296-9790 Blue Medicare HMO/PPO

Incomplete Form May Delay Processing

Prescriber Information		Patient Information
Physician Name:	NPI #:	Patient Name:
Office Contact Person:		Patient ID #:
Office Phone #:	Office Fax #:	Home Phone #:
Address:		Sex: ☐ Female ☐ Male
City: State: Zip:		DOB:

Diagnosis and Medication Information	
Medication Requested:	Diagnosis Code:
Strength and Route of Administration:	

Please answer questions below

Initial Evaluation (Renewal evaluation on page 3)

1. Is this request for an expedited review? ☐ Yes ☐ No
   Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. *A standard review will have a decision made within 72 hours for a coverage determination.*

2. Please select the diagnosis for the requested medication:
   - ☐ **Crohn's disease**
     - A. Does the patient have moderately to severely active Crohn's disease? ☐ Yes ☐ No
   - ☐ **Plaque psoriasis**
     - A. Does the patient have moderate to severe plaque psoriasis? ☐ Yes ☐ No
   - ☐ **Psoriatic arthritis**
   - ☐ **Ulcerative colitis (UC)**
     - A. Does the patient have moderately active UC? ☐ Yes ☐ No
       - i. **If NO**, does the patient have severely active UC? ☐ Yes ☐ No
   - ☐ **Other (please specify)**: _____

3. Is the patient currently being treated with the requested medication (within the past 90 days)? ☐ Yes ☐ No
   - A. **If YES to 3.**, is the patient at risk if therapy is changed? ☐ Yes ☐ No
     - i. **If YES to 3A.,** please **provide clinical justification** to support that the patient is at risk if therapy is changed. Medical records may be sent in for review.

     _____
     _____
     _____

PLEASE CONTINUE TO NEXT PAGE

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B. **If NO to 3. or 3.A.**, has the patient used another biologic immunomodulator medication for the same FDA labeled indication as the requested medication?..... ☐ Yes ☐ No

i. **If NO to 3.B.**, what formulary conventional prerequisite medications has the patient been previously treated with?_____
_____

ii. Does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to any formulary conventional prerequisite medications?..... ☐ Yes ☐ No

a. **If YES**, please specify which: _____
_____

4. Will the patient be using the requested medication in combination with another biologic immunomodulator?..... ☐ Yes ☐ No

I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature:_____ Date: _____

Updated: 01/01/2023

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Address:		Sex: ☐ Female ☐ Male
City: State: Zip:		DOB:

Diagnosis and Medication Information	
Medication Requested:	Diagnosis Code:
Strength and Route of Administration:	

Please answer questions below

Renewal Evaluation (Initial evaluation on page 1)

1. Is this request for an expedited review?..... ☐ Yes ☐ No
   Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. *A standard review will have a decision made within 72 hours for a coverage determination.*

2. Has the patient been previously approved for the requested medication through the plan's Prior Authorization criteria?..... ☐ Yes ☐ No

3. Please select the diagnosis for the requested medication:
   - ☐ **Crohn's disease**
   - ☐ **Plaque psoriasis**
   - ☐ **Psoriatic arthritis**
   - ☐ **Ulcerative colitis**
   - ☐ **Other (please specify):** _____

4. Has the patient had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency)?..... ☐ Yes ☐ No

5. Will the patient be using the requested medication in combination with another biologic immunomodulator?..... ☐ Yes ☐ No

I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature:_____ Date: _____

Updated: 01/01/2023