

Biologic Immunomodulators

Prior Authorization (PA) Request Form

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

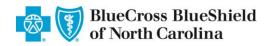
Fax: 888-446-8535

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

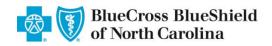
		Form May Delay Processing		
	er Information	Patient Information		
Physician Name:	NPI #:	Patient Name:		
Office Contact Person:		Patient ID #:		
Office Phone #:	Office Fax #:	Home Phone #:		
Address:		Sex: □ Female □ Male		
City:	State: Zip:	DOB:		
	Diagnosis a	nd Medication Information		
Medication Requested:		Diagnosis Code:		
Strength and Route of Admi	nistration:			
	Please a	nswer questions below		
		(Renewal evaluation on page 3)		
Check the "Yes" box to believes that waiting for	request an expedited revion a decision under the stan m function in serious jeop	lew if the enrollee or his/her physician or other prescriber ndard time frame may place the enrollee's life, health, or pardy. A standard review will have a decision made within 72		□ No
 Please select the diagnos □ Crohn's disease A. Does the patien 		dication: verely active Crohn's disease?	.□ Yes	□ No
☐ Plaque psoriasis A. Does the patier	it have moderate to seve	ere plaque psoriasis?	. □ Yes	□ No
☐ Psoriatic arthritis				
	nt have moderately active	e UC?ly active UC?		
☐ Other (please spec	ify):			
A. If YES to 3., is i. If YES to 3.	the patient at risk if thera A. , please provide clinic	nested medication (within the past 90 days)? apy is changed? cal justification to support that the patient is at risk if s may be sent in for review.		
	DI FAOF			
	PLEASE (CONTINUE TO NEXT PAGE		



Biologic Immunomodulators Stelara

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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? i. If NO to 3.B., what formulary conventional prerequisite medications has the patient been previously treated with?	. □ Yes	□ No
ii. Does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to any formulary conventional prerequisite medications?	. □ Yes	□ No
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 of I further certify that the patient's medical records accurately reflect the information provided. I understand the NC may request medical records for this patient at any time in order to verify this information.		
Physician Signature: Date:		



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Incomplete Form May Delay Processing							
Prescribe	er 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 ar	nd Medication Information					
Medication Requested:		Diagnosis Code:					
Strength and Route of Admir	nistration:						
	Please ar	nswer questions below					
		on (Initial evaluation on page 1)					
 Is this request for an expedited review? 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. Has the patient been previously approved for the requested medication through the plan's Prior Authorization criteria? Please select the diagnosis for the requested medication: Crohn's disease Plaque psoriasis Psoriatic arthritis 							
☐ Ulcerative colitis☐ Other (please special	ify):						
		of disease progression or decrease in symptom ☐ Yes	□ No				
5. Will the patient be using the immunomodulator?	ne requested medication	in combination with another biologic ☐ Yes	□ No				
I further certify that the patie	nt's medical records accu	coverage determination for the medication indicated on this requrately reflect the information provided. I understand that Blue Cany time in order to verify this information.					
Physician Signature:		Date:					