BlueCross BlueShield Federal Employee Program®

ILUMYA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard and Basic Option patients Enbrel, Humira, Otezla, Skyrizi, Stelara SC, Taltz, and Tremfya are preferred products. Standard/Basic Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Ilumya (tildrakizumab-asmn)

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

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

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

Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit: Would you like to switch the patient to a preferred product? ❑Yes***** ❑No

If YES, please select the preferred product: ❑Enbrel ❑Humira ❑Otezla ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya

1. What is the patient's diagnosis?
   ❑Plaque Psoriasis (PsO)
   a. Does the patient have moderate to severe plaque psoriasis? ❑Yes ❑No
   ❑Other diagnosis ***(please specify)***:_____
2. Does the patient have any active infections, including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
3. Will the patient be given live vaccines while on Ilumya therapy? ❑Yes ❑No
4. Will Ilumya be used in combination with any other biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARD includes: Actemra, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, and Xeljanz/Xeljanz XR
5. Does the prescriber agree to administer Ilumya within the FDA labeled maintenance dose of 100mg every 12 weeks? ❑Yes ❑No
6. Has the patient been receiving Ilumya for at least **6 months** continuously, excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   a. Does the patient have a contraindication to or have they had either an inadequate response or intolerance to conventional systemic therapy? ***Please select answer below:***
   ❑Inadequate response ❑Intolerance or contraindication ❑Has not tried conventional systemic therapy
   b. Does the patient have a contraindication to or have they had either an inadequate response or intolerance to phototherapy?
   ❑Inadequate response ❑Intolerance or contraindication ❑Has not tried phototherapy
   c. 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? ❑Negative ❑Positive*
   If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Has the patient's condition improved or stabilized with Ilumya? ❑Yes ❑No

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

BlueCross BlueShield Federal Employee Program

ILUMYA
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 2 - PHYSICIAN COMPLETES

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

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

1. Does the patient have a history of demyelinating disorder? ❑Yes ❑No
2. Does the patient have a history of congestive heart failure? ❑Yes ❑No
3. Does the patient have a history of Hepatitis B Virus (HBV) infection? ❑Yes ❑No
4. Does the patient have autoantibody formation / lupus-like syndrome? ❑Yes ❑No
5. Does the patient have a contraindication to or have they had either an inadequate response or intolerance to **TWO** of the preferred products: ***Please select answer below:***

   ❑**Yes:** please specify the preferred product(s) and result(s) below:

   _____

   _____

   ❑**No:** Is there a clinical reason for not trying **TWO** of the preferred products? ❑Yes***** ❑No

   ****If YES***, please describe the clinical reason below:

   _____

   _____

BlueCross BlueShield
Federal Employee Program

ILUMYA
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

Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Ilumya – FEP MD Fax Form Revised 11/16/2021