

**HEALTHCARE PROVIDER ADMINISTERED BIOLOGIC IMMUNOMODULATORS
Preauthorization Request
(Preauthorization is not a guarantee of payment)**

SECTION I – General Information

| | |
|--|---|
| Today's Date: | <input type="checkbox"/> New request |
| Fax completed form to: 1-866-805-4150 toll free | <input type="checkbox"/> Re-Authorization |

Level of Urgency:

Standard Request (Routine Care)—Care/treatment that is not emergent, urgent, or preventive in nature.

Expedited Request—Care/treatment that is emergent or the application of the timeframe for making Standard/Routine or nonlife-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For Expedited Request, Please Explain:

SECTION II – Member Information

| | | |
|-------------------|------------------------------|---|
| Patients Name: | Member ID: | Patient Information: |
| | | DOB: |
| Patients Address: | Is CBC primary payer: | Sex: |
| | <input type="checkbox"/> Yes | Age: |
| | <input type="checkbox"/> No | Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> Kg |
| | | Will the patient self-administer the requested medication? |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Plan Type:

PPO POS KHPC CHIP (aka Capital Cares 4Kids)
 Traditional Comprehensive Special Care Other* _____

**NOTE: For all Medicare Advantage products, please contact Prime Therapeutics at <https://www.covermy meds.com/main> or via phone at 1-866-260-0452.*

SECTION III – Provider Information Required

| | |
|---------------------------------------|--|
| Requesting Provider Name: Address: | Requesting Provider CBC # _____ NPI # _____ |
| Telephone #: | Secure Fax #: |
| Office Contact Name: | Office Contact Telephone #: |

Is the Rendering/Serviceing provider different? No Yes – Complete rendering provider information below.

| | |
|--|---|
| Rendering Provider Name: Telephone: Address: Telephone: | Rendering Provider CBC # _____ NPI # _____ |
| Site of Service: <input type="checkbox"/> MD Office <input type="checkbox"/> Home Health <input type="checkbox"/> Non-hospital affiliated, outpatient infusion center <input type="checkbox"/> Hospital affiliated, outpatient infusion center <input type="checkbox"/> Other: Specify _____ <i>*Please refer to MP 3.016 for Site of Service requirements.</i> | Check all that apply and include all applicable documentation: <input type="checkbox"/> There are contraindications to a less intensive site of care. <input type="checkbox"/> A less intensive site of care is not appropriate for the patient's condition. <input type="checkbox"/> Patient is being treated with a drug that cannot be administered in a less intensive site of care concurrently. <input type="checkbox"/> Less intensive site of care is not available. <i>*Please include all applicable documentation.</i> |
| SECTION IV – Preauthorization Requirements and Clinical Criteria | |
| Prescribed in consultation with a specialist? <input type="checkbox"/> Yes Specialty: _____ <input type="checkbox"/> No | |
| <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy*: Initial start <input type="checkbox"/> Reinitiating therapy: Last treatment <i>*Please include documentation for changes in dose.</i> | Route of Administration: <input type="checkbox"/> Intravenous (IV) <input type="checkbox"/> Injection (Sub Q or IM) <input type="checkbox"/> Oral (PO) or Enteral <input type="checkbox"/> Other: Specify _____ |
| HCPC Code(s): | Diagnosis Code(s): |
| Medication requested: | Indication: |
| Type of drug requested: <input type="checkbox"/> Brand name <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar <input type="checkbox"/> Other: Specify _____ | |
| Initial start date of therapy: | Anticipated date of next administration: |
| Dosing period for request: Start Date: End Date | Dosing Information: Dose: Strength: Frequency: Quantity requested per month: |
| Attach documentation demonstrating the medical necessity of the requested drug. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max.) | |
| Has the patient had medical testing completed for use of this drug? (labs, imagining) <input type="checkbox"/> Yes <input type="checkbox"/> No Results: _____ | |
| Is drug being requested for an “off label” indication ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please see Medical Policy 2.103 and include any applicable documentation. | |

Please list any previous medications that were **tried and failed**. Include reason for discontinuation (intolerance, hypersensitivity, inadequate response etc.). Please attach documentation.

Drug(s) and strength:

Documentation of failure:

Healthcare Provider Administered (HCPA) Biologic Immunomodulator

- Actemra (tocilizumab)
- Cimzia (certolizumab pegol)
- Ilumya (tidrakizumab)
- Inflectra (infliximab-dyyb)
- Renflexis (infliximab-abda)
- Stelara (ustekinumab)
- Orencia (abatacept)
- Simponi ARIA (golimumab)
- Remicade (infliximab)
- Entyvio (vedolizumab)
- Inflectra (infliximab -dyyb)
- Avsola (infliximab-axxq)
- Taltz (ixekizumab)

What is the patient's diagnosis?

- Moderately to severely active rheumatoid arthritis (RA)
- Granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis)
- Active psoriatic arthritis (PsA)
- Chronic severe plaque psoriasis (PS)
- Moderately to severely active Crohn's disease (CD)
- Moderately to severely active ulcerative colitis (UC)
- Active ankylosing spondylitis (AS)
- Cytokine Release Syndrome (CRS)
- Giant Cell Arteritis (GCA)
- Hidradenitis Suppurativa (HS)
- Juvenile Idiopathic Arthritis (JIA)
- Polyarticular Juvenile Idiopathic Arthritis (PJIA)
- Other: Specify _____

Has the patient been tested for latent tuberculosis (TB)? If so, results were:

- Negative
- Positive: if positive has the patient begun therapy for latent TB? Yes No

Has the patient tried and had an inadequate response to maximally tolerated methotrexate (e.g., titrated to 25 mg weekly) for at least 3-months? Yes No

Has the patient tried and had an inadequate response to another conventional agent used in the treatment of RA (e.g., hydroxychloroquine, leflunomide, sulfasalazine) for at least 3-months? Yes No Will the requested agent be used in combination with methotrexate or an alternative DMARD (e.g. leflunomide, hydroxychloroquine, sulfasalazine, etc)? Yes No

Does the patient have refractory or treatment-resistance GPA? Yes No

Will the requested agent be used in combination with a corticosteroid? Yes No

Has the patient tried and had an inadequate response to BOTH cyclophosphamide and rituximab for at least 3-months? Yes No

Has the patient tried and had an inadequate response to an alternative immunosuppressive (e.g. azathioprine, methotrexate, or mycophenolate mofetil) for at least 3-months? Yes No

Has the patient tried and had an inadequate response to ONE conventional agent used in the treatment of PsA (e.g., cyclosporine, leflunomide, methotrexate, sulfasalazine) for at least 3-months? Yes No

Does the patient have severe active PsA (e.g., erosive disease, elevated markers of inflammation attributable to PsA, long-term damage that interferes with function [i.e., joint deformities], rapidly progressive)? Yes No

Does the patient have concomitant severe psoriasis (PS) (e.g., greater than 10% body surface area involvement, occurring on select locations [i.e., hands, feet, scalp, face, or genitals], intractable pruritus, serious emotional consequences)? Yes No

Does the patient have severe active PS (e.g., greater than 10% body surface area involvement, occurring on select locations [i.e., hands, feet, scalp, face], intractable pruritus, serious emotional consequences)? Yes No

Does the patient have concomitant severe psoriasis (PsA) (e.g., erosive disease, elevated markers of inflammation [e.g., ESR, CRP] attributable to PsA, long-term damage that interferes with function [i.e., joint deformities], rapidly progressive)? Yes No

Has the patient tried and had an inadequate response to ONE conventional agent used in the treatment of CD (e.g., 6-mercaptopurine, azathioprine, corticosteroids [e.g., prednisone, budesonide EC capsule], methotrexate, sulfasalazine) for at least 3-months? Yes No

Has the patient tried and had an inadequate response to ONE conventional agent used in the treatment of UC (e.g., 6-mercaptopurine, azathioprine, balsalazide, corticosteroids, cyclosporine, mesalamine, steroid suppositories, sulfasalazine) for at least 3-months? Yes No

Has the patient tried and had an inadequate response to ONE conventional agent used in the treatment of PS (e.g., acitretin, anthralin, calcipotriene, calcitriol, coal tar products, cyclosporine, methotrexate, pimecrolimus, PUVA [phototherapy], tacrolimus, tazarotene, topical corticosteroids) for at least 3-months? Yes No

Has the patient tried and had an inadequate response to two different NSAIDs for at least a 4-weeks? Yes No

Is the patient currently being treated with another biologic immunomodulator agent? Yes No

Will the other biologic immunomodulator agent be discontinued prior to starting the requested agent? Yes No

For renewals: Has the patient had clinical benefit with the requested agent? Yes No

Does the patient have severely active ulcerative colitis? Yes No

Does the patient have an FDA labeled contraindication to an above listed drug? Specify: _____

***Include all applicable documentation for request.**

Please use a separate form for each drug.

To fill out form type or write using blue or black ink

Please fax this form to: 1-866-805-4150

Telephone: 1-800-471-2242

Prior authorization is not a guarantee of payment; benefits and eligibility will apply at the time of claim adjudication.

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