(Revised 1/2023)

blue of california

FEP PPO PRESCRIPTION DRUG PRIOR AUTHORIZATION Avsola

Plan/Medical Group Name: Blue Shield of California

Plan Phone#: (800) 633-4581

☐ **Non-Urgent-** The Federal Employee Program has a **72- hour turn-around time on medications that requires Prior Authorization** according to the Blue Cross Blue Shield Service Benefit Plan. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information **FAX TO: 844-224-0226**

☐ **Urgent Request-** Please note, scheduling issues do not meet the definition of Urgent. ***Definition of an Urgent Request:*** An imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision making might seriously jeopardize the life or health of the member. **FAX TO: 844-224-0226**

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____Weight (lb/kg):_	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information

Medication Name and HCPCS or CPT Code:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration: ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location: ☐ Physician's Office ☐ Outpatient Hospital Care	☐ Patient's Home ☐ Home Care Agency	☐ Long Term Care ☐ Ambulatory Infusion Center ☐ Other (explain):

PRESCRIPTION DRUG PRIOR AUTHORIZATION

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. What is the patient' Diagnoses:	**ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances or required under state and federal laws.

1. Please provide the following info:

☐ **Crohn's Disease** ***(aka regional enteritis)*** – ***Answer questions below:***
   a. Does the patient have moderate to severe Crohn's disease, either active or in remission? ☐Yes ☐No*
      If NO, is the patient's Crohn's disease fistulizing? ☐Yes ☐No
   b. If between the ages of 6-17, will all vaccinations be up to date prior to start of therapy? ☐Yes ☐No

☐ **Ulcerative Colitis** – ***Answer questions below:***
   a. Does the patient have moderate to severe active ulcerative colitis? ☐Yes ☐No
   b. Has there been inadequate response to conventional therapy, unless contraindicated or intolerant? ☐Yes ☐No
   c. If between the ages of 6-17, will all vaccinations be up to date prior to start of therapy? ☐Yes ☐No

☐ **Rheumatoid Arthritis** – ***Answer questions below:***
   a. Does the patient have moderate to severe active rheumatoid arthritis? ☐Yes ☐No
   b. Is the patient using concurrent therapy with methotrexate? ☐Yes☐No*
      If NO, is the patient contraindicated or intolerant to the use of methotrexate? ☐Yes ☐No

☐ **Ankylosing Spondylitis** – ***Answer question below:***
   a. Is the patient's ankylosing spondylitis active? ☐Yes ☐No

☐ **Psoriatic Arthritis** – ***Answer question below:***
   a. Is the patient's psoriatic arthritis active? ☐Yes ☐No

☐ **Plaque Psoriasis** – ***Answer questions below:***
   a. Is the patient's plaque psoriasis chronic severe (i.e., extensive and/or disabling)? ☐Yes ☐No
   b. Has there been inadequate response to conventional therapy, unless contraindicated or intolerant? ☐Yes ☐No

☐ **Other (*please specify*):** _____

2. Will Avsola be used in combination with another biologic agent? ☐Yes ☐No
   If yes, please specify agent: _____

3. Is this the **INITIATION** or **CONTINUATION** of Avsola therapy?

☐This is the **INITIATION** of Remicade therapy – ***Answer questions below:***
   a. Has the patient had a TB test prior to initiating therapy that confirms no active tuberculosis? ☐Yes ☐No*
      If NO, does the patient have a latent tuberculosis infection? ☐Yes* ☐No
         If YES, has the patient started treatment for the infection prior to the use of Avsola? ☐Yes☐No
         b. Does the patient have any active infections? ☐Yes☐No
   c. Is the patient at risk for Hepatitis B infection (HBV)? ☐Yes* ☐No
      If YES, has HBV been ruled out for this patient or has therapy been started for treatment of the HBV infection? ☐Yes ☐No

☐This is the **CONTINUATION** of Avsola therapy – ***Answer questions below:***
   a. Has the patient's condition improved or stabilized? ☐Yes ☐No
   b. Does the patient have any active infections including tuberculosis (TB) and Hepatitis B (HBV)? ☐Yes ☐No
   c. Did the patient have an inadequate treatment response to the initial dosing regimen, and is therefore considered a non-responder? ☐Yes☐No

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification:_____ **Date**:_____

Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer:_____ Date/Time of Decision_____
Fax Number (_____)_____

Approved Denied Comments/Information Requested: _____