

(Revised 1/2023)

FEP PPO PRESCRIPTION DRUG PRIOR AUTHORIZATION Inflectra

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 medication 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:	<input type="checkbox"/> Male <input type="checkbox"/> 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:					
<input type="checkbox"/> New Therapy		<input type="checkbox"/> Renewal			
If Renewal: Date Therapy Initiated:			Duration of Therapy (specific dates):		
How did the patient receive the medication?					
<input type="checkbox"/> Paid under Insurance		Name: _____		Prior Auth Number (if known): _____	
<input type="checkbox"/> Other (explain):					
Dose/Strength:	Frequency:	Length of Therapy/#Refills:		Quantity:	
Administration: <input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other:					
Administration Location: <input type="checkbox"/> Physician's Office		<input type="checkbox"/> Patient's Home		<input type="checkbox"/> Long Term Care <input type="checkbox"/> Ambulatory Infusion Center	
<input type="checkbox"/> Outpatient Hospital Care		<input type="checkbox"/> Home Care Agency		<input type="checkbox"/> Other (explain):	

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PRESCRIPTION DRUG PRIOR AUTHORIZATION

Patient Name:	ID#:
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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.		

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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 Inflectra 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 Inflectra?* 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 Inflectra 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:** _____

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Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer: _____ Date/Time of Decision _____
 Fax Number (_____) _____
 Approved Denied Comments/Information Requested: _____