BlueCross BlueShield of North Carolina

Biologic Immunomodulators
Xeljanz
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

Incomplete Form May Delay Processing

Prescriber 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 and Medication Information	
Drug Requested:	Diagnosis Code:
Strength and Route of Administration:	

Please answer questions below

Initial Evaluation
(Renewal evaluation on page 3)

1. Is this request for an expedited review?..... ☐ Yes ☐ No
   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.*

2. Please select the diagnosis for the requested drug:
   - ☐ **Psoriatic arthritis**
   - ☐ **Rheumatoid arthritis**
   - ☐ **Ulcerative colitis**
   - ☐ **Other (please specify):**_____

3. Is the patient currently (within the past 90 days) being treated with the requested agent?..... ☐ Yes ☐ No
   A. **If YES to 3.**, is the patient at risk if therapy is changed?..... ☐ Yes ☐ No
   B. **If NO to 3. or 3.A.**, please list the name(s) of other biologic immunomodulator agent(s) the patient has previously tried, OR has a documented intolerance, FDA labeled contraindication, or hypersensitivity to: _____
   _____
   _____

4. Is the patient currently being treated with another biologic immunomodulator?..... ☐ Yes ☐ No
   A. **If YES**, will the current biologic immunomodulator be discontinued prior to starting the requested agent?..... ☐ Yes ☐ No

PLEASE CONTINUE TO NEXT PAGE

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I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature: _____ Date: _____

Updated: 01/01/2020

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Address:		Sex: ☐ Female ☐ Male
City: State: Zip:		DOB:

Diagnosis and Medication Information	
Drug Requested:	Diagnosis Code:
Strength and Route of Administration:	

Please answer questions below

1. Is this request for an expedited review?..... ☐ Yes ☐ No
   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.*

2. Has the patient been previously approved for the requested agent through the plan's Prior Authorization criteria?..... ☐ Yes ☐ No

3. Please select the diagnosis for the requested drug:
   - ☐ **Psoriatic arthritis**
   - ☐ **Rheumatoid arthritis**
   - ☐ **Ulcerative colitis**
   - ☐ **Other (please specify):**_____

4. Has the patient shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency)?..... ☐ Yes ☐ No

5. Is the patient currently being treated with another biologic immunomodulator?..... ☐ Yes ☐ No
   A. **If YES**, will the current biologic immunomodulator be discontinued prior to starting the requested agent?..... ☐ Yes ☐ No

I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature:_____ Date: _____

Updated: 01/01/2020

Members HMO:

Blue Cross and Blue Shield of North Carolina complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-310-4110 (TTY: 1-888-451-9957).
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-310-4110（TTY：1-888-451-9957）。

Members PPO:

Blue Cross and Blue Shield of North Carolina complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-494-7647 (TTY: 1-888-451-9957).
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-494-7647（TTY：1-888-451-9957）。

Members Rx (PDP):

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- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-247-4142 (TTY: 1-888-247-4145).
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-247-4142（TTY：1-888-247-4145）。