BlueCross BlueShield of Texas

For TRS-ActiveCare Participants

Medical Benefit Medication Administration Site of Care Benefit Exception Request Form

For select infused or injected medications listed in active TRS-approved appendices to ADMMEDSOC001-TRS

Use this form to request a benefit exception allowing hospital outpatient administration of select medications. This review determines site-of-care exception coverage only. It does not determine medication medical necessity, drug coverage, indication coverage, or any other prior authorization requirement.

Important coverage rule: Hospital outpatient administration of a listed medication is excluded unless a site-of-care benefit is approved. All requests must satisfy Section 5 of the administrative policy and any drug-specific policy appendix requirements that apply to the requested medication. It also does not guarantee coverage under the benefit plan. You will receive written notice once a determination has been made for coverage.

Fax each completed Coverage Exception Request Form to 1-800-252-8815. You can also attach this form with your prior authorization request.

BENEFIT EXCEPTION REQUEST INFORMATION			
☐ **Standard Priority**	☐ **Urgent / Expedited Priority** (Expedited requests may be submitted when a delay might impact treatment scheduling. If it does not meet the definition of urgent, the request will be re-classified as standard priority.)		
Today's Date:	/ /	**Anticipated Date of Service:**	/ /
Request Number (if known):			
SUBMITTING / RENDERING PROVIDER / FACILITY INFORMATION			
Submitting Provider or Facility Name:			
NPI (Organization Type 2, if applicable):			
Tax ID:			
Contact First Name:		**Contact Last Name:**	
Telephone Number:		**Fax Number:**	
Hospital Outpatient Facility Where Service is Requested:			
PRESCRIBING / ORDERING / TREATING PROVIDER INFORMATION			
Provider First Name:		**Provider Last Name:**	
NPI (Individual Type 1):			
Specialty:			
Telephone Number:		**Fax Number:**	

MEMBER INFORMATION

Member First Name:	**Member Last Name:**
Member Identification Number: (Include the 3-digit prefix)	
Group Number:	**Date of Birth:** / /

MEDICATION REQUESTED

Select requested listed medication: ☐ Skyrizi® (risankizumab) ☐ Tremfya® (guselkumab)

HCPCS code / dose / schedule:

Requested Site of Care: ☐ Hospital Outpatient Dėpartment ☐ Other:

Lower-Level Site(s) Considered (check all that apply):	☐ Physician Office / Clinic	☐ Freestanding Infusion Center	☐ Home Infusion	☐ Not Available

A benefit exception request cannot be approved based on drug-specific criteria alone. The benefit exception request must document at least one qualifying general site-of-care exception criterion AND must meet the applicable drug-specific requirements below.

GENERAL SITE-OF-CARE EXCEPTION CRITERIA
(Required for every medication)

Select at least one criterion and attach documentation. General criteria apply to every listed medication, including Skyrizi and Tremfya.

☐ **Prior Significant Administration Reaction:** History of a moderate or severe infusion or injection-related reaction, anaphylaxis, or other clinically significant administration-related event requiring enhanced monitoring beyond routine lower-level outpatient capabilities.

☐ **Clinical Instability Requiring Hospital Level Monitoring:** The member's current condition requires immediate access to hospital-level monitoring, equipment, or staff during administration.

☐ **Combination Regimen Requiring Hospital Outpatient Administration**: The requested medication is administered on the same date of service as one or more additional infused or injected medications or services that, by benefit design or documented clinical requirement, are covered only in a hospital outpatient setting, and separation across sites is not clinically or operationally appropriate.

☐ **Complex or High-Risk Administration:** Clinical characteristics of the medication or patient require direct supervision with rapid access to emergency services or hospital-level intervention.

☐ **Re-Initiation After Interruption or Hospitalization:** The requested service is the first dose or early re-initiation dose following a prolonged interruption due to prior adverse reaction, clinical instability, or hospitalization, and documentation supports enhanced monitoring.

☐ **Access Limitation:** No qualifying lower-level outpatient site of care capable of administering the medication is available within a reasonable geographic distance or within a timeframe consistent with the treatment schedule.

☐ **Home Infusion Administration Not Appropriate:** The home setting is not suitable due to safety, caregiver availability, environmental concerns, or inability to meet required administration or monitoring needs when home infusion is the only otherwise available lower-level option.

☐ **Drug-Specific Criterion:** The member meets an additional or modified medication-specific criterion in the applicable section below.

Supporting Explanation:

SKYRIZI® (risankizumab) AND TREMFYA® (guselkumab) DRUG-SPECIFIC REQUIREMENTS

Complete only for Skyrizi or Tremfya. The general criteria remain required. This section does not add a separate clinical exception criterion beyond the general criteria, but requests must satisfy the below medication, indication, phase, dose, and duration requirements. Check all that apply.

☐ **Medication Requirement:** Requested medication is Skyrizi® (risankizumab) or Tremfya® (guselkumab).

☐ **Indication Requirement:** Requested medication is for ulcerative colitis or Crohn's disease. Site-of-care review does not determine whether the medication is covered for the requested indication.

☐ **IV Induction Phase Requirement:** Hospital outpatient benefit exception request is limited to the intravenous induction phase only.

☐ **Dose Limitation:** Requested dose is one of the first three IV induction doses (Week 0, Week 4, or Week 8).

☐ **Maintenance Limitation:** Approval does not extend to subcutaneous maintenance doses unless TRS adopts separate criteria for that use.

Requested Medication and Induction Dose: ☐ Skyrizi ☐ Tremfya ☐ Week 0 ☐ Week 4 ☐ Week 8 Anticipated date: ___ / ___ / _____

Supporting Explanation for an Exception:

FACTORS NOT SUFFICIENT ALONE

The following are not sufficient by themselves without documentation showing a qualifying clinical, safety, operational, or access condition: Generalized high-risk designation, stable chronic conditions without imminent administration-related risk, convenience, provider preference, member preference, routine monitoring needs, historical hospital outpatient use, transportation barriers, missed appointments, or generalized social concerns.

SUPPORTING DOCUMENTATION
(check all that apply)

☐ Recent provider progress note or clinical summary	☐ Administration history, including prior infusion or injection reactions
☐ Treatment regimen details and anticipated administration schedule	☐ Clinical rationale for hospital outpatient administration
☐ Lower-level site availability or access limitation documentation	☐ Combination regimen / same-date service documentation
☐ Skyrizi/Tremfya indication and IV induction dose documentation	

☐ Other supporting records:

ATTESTATION

☐ I certify that the information provided is accurate and complete and supports this benefit exception request for a hospital outpatient site-of-care benefit exception under ADMMEDSOC001-TRS. I understand that approval authorizes the site of care only and does not grant or deny coverage of the medication itself.

Authorized Signature: _____ **Date:** _____/_____/_____

All sections must be completed. Any missing documentation may result in an automatic denial of benefit coverage.