BlueCross BlueShield of Texas

For TRS-ActiveCare Participants

Medical Benefit Step Therapy Exception Form

For select drugs used to treat Crohn's Disease and Ulcerative Colitis

Use this form only to request a **benefit exception to step therapy requirements** for select medications used to treat Crohn's Disease and Ulcerative Colitis. **It applies to active TRS-approved appendices to ADMIL23EX001**.

Important coverage rule: This form evaluates **medical benefit exception criteria only** and does not determine overall medical necessity of the medication itself. 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.

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:**	/ /
SUBMITTING 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:**	
PRESCRIBING / 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 AND DIAGNOSIS

SELECT THE MEDICATION, TREATMENT AND MEDICAL DIAGNOSIS. ***Please Note:*** *Requests for any other medical diagnosis do not meet the benefit criteria.*	
☐ Skyrizi® (risankizumab-rzaa)	☐ Tremfya® (guselkumab)
☐ Initial Request	☐ Continuation of Therapy
☐ Crohn's Disease	☐ Ulcerative Colitis

STEP THERAPY HEALTH PLAN EXCEPTION

ALL SECTIONS BELOW MUST BE COMPLETED AND ATTACH ANY SUPPORTED DOCUMENTATION

INADEQUATE RESPONSE TO CONVENTIONAL THERAPY

Inadequate response, intolerance or contraindication ≥ 12 weeks to ≥ 1 of the following (must select one):	☐ Corticosteroids (e.g. prednisone, budesonide)	☐ 6-mertcaptopurine	☐ Azathioprine	☐ Methotrexate

Details (drug, duration, outcome):

REQUIRED BIOLOGIC THERAPY (SELECT ONE PATHWAY)

PATHWAY A – BIOLOGIC FAILURE OR INADEQUATE RESPONSE OF:	**PATHWAY B – INTOLERANCE / CONTRAINDICATION TO:**
☐ adalimumab or infliximab trial ≥ 12 weeks ☐ ustekinumab trial ≥ 12 weeks ☐ Inadequate response to BOTH medications	☐ adalimumab ☐ ustekinumab ☐ Intolerance/contraindication response to BOTH medications

Clinical details:

ADDITIONAL ADVANCED THERAPY REQUIREMENT

FOR CROHN'S DISEASE:	**FOR ULCERATIVE COLITIS:**
Inadequate response following a trial ≥ 12 weeks of therapy, or documented intolerance or contraindiction, with: ☐ Entyvio® (vedolizumab)	Inadequate response following a trial ≥ 12 weeks of therapy, or documented intolerance or contraindiction, with: ☐ Entyvio® (vedolizumab) AND tofacitinib

Clinical details:

SUPPORTING DOCUMENTATION

(Check all that apply. Supporting documentation must be provided for each checked criterion.)

☐ Treatment history (drug, dose, duration)	☐ Clinical response / inadequate response documentation
☐ Adverse event / intolerance documentation	☐ Contraindication rationale
☐ Other records	

CLINICAL ATTESTATION

I certify that the information provided is accurate and complete and supports this request **for a step therapy health plan exception.**

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

All sections must be completed. Any missing documentation may result in an automatic denial of health plan coverage. Medication history that has not been documented with duration or outcomes does not meet the step therapy health plan exception criteria. Where applicable, there is a minimum of 12 weeks required for biologic trials.