BlueCross BlueShield Federal Employee Program.

AUBAGIO
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❒Male ❒Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

For Standard and Basic Option patients teriflunomide (GENERIC Aubagio), Avonex, Betaseron, Glatopa, Mayzent, Plegridy, Rebif, Zeposia, dimethyl fumarate (generic Tecfidera), fingolimod (generic Gilenya), and glatiramer acetate (generic Copaxone) are preferred products. Standard/Basic Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Aubagio (teriflunomide)

NOTE: Form must be completed in its **entirety** for processing

Select Strength (*package size is 30 tablets*): ❒**7mg** ❒**14mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑ Brand ❑ Generic

How many tablets will the patient need for a 90 day supply? _____ tablet(s) per 90 days

1. **BRAND Aubagio Request** (**Standard/Basic Option)**: Would you like to switch the patient to the preferred product, teriflunomide (**generic** Aubagio)? ❒Yes ❒No*****

   If NO, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to teriflunomide (**generic** Aubagio)? ***Please select answer below:***

   ❑**Yes** ***(specify result)***: _____

   ❑**No**: Is there a clinical reason for not trying, teriflunomide (**generic** Aubagio)? ❑Yes***** ❑No

   If YES, please specify: _____

2. **BRAND Aubagio Request** (**Standard/Basic Option):** Would you like to switch the patient to a preferred product: Avonex, Betaseron, Glatopa, Mayzent, Plegridy, Rebif, Zeposia, dimethyl fumarate (**generic** Tecfidera), fingolimod (**generic** Gilenya), or glatiramer acetate (**generic** Copaxone)? ***Please select answer below:***

   ❑**Yes** ***(select preferred product)***: ❑Avonex ❑Betaseron ❑Glatopa ❑Mayzent ❑Plegridy ❑Rebif ❑Zeposia
   ❑dimethyl fumarate (**generic** Tecfidera) ❑fingolimod (**generic** Gilenya)
   ❑glatiramer acetate (**generic** Copaxone)

   ❑**No**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to any of the preferred products? ***Please select answer below:***

   ❑**Yes** ***(specify drug(s) and result(s))***: _____

   _____

   ❑**No**: Is there a clinical reason for not trying the preferred products? ❑Yes***** ❑No

   If YES, please specify: _____

3. What is the patient's diagnosis?
   ❒Active secondary progressive multiple sclerosis ❒Relapsing-remitting multiple sclerosis
   ❒Clinically Isolated Syndrome (CIS) ❒Relapsing Multiple Sclerosis (MS)
   ❒Other diagnosis ***(please specify)***: _____

4. Does the patient have severe hepatic impairment? ❒Yes ❒No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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Patient Name: _____ DOB: _____ Patient ID: R _____

5. **FEMALE Patient**: Is the patient of reproductive potential? ❒Yes***** ❒No
   If YES, is the patient pregnant? ❒Yes ❒No*****
   If NO, will the patient be advised to use reliable contraception during treatment with Aubagio? ❒Yes ❒No

6. Will the patient be given live vaccines while on Aubagio? ❒Yes ❒No

7. Will the patient be on concomitant therapy with Arava (leflunomide)? ❒Yes ❒No

8. Will Aubagio be used in combination with other MS disease modifying agents? ❒Yes***** ❒No
   If YES, please specify medication: _____

9. Has the patient been on Aubagio continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❒**NO –** this is **INITIATION** of therapy, please answer the following questions:

a. Have the patient's transaminase and bilirubin levels been checked within the last six months? ❒Yes ❒No

b. Has the patient been tested for latent tuberculosis (TB)? ❒Yes***** ❒No
   If YES, what was the result of the test positive or negative for TB infection? ❒Negative ❒Positive*****
   If POSITIVE, has the patient completed treatment for latent TB? ❒Yes ❒No

c. Does the patient have any active infections? ❒Yes ❒No

d. **Teriflunomide (GENERIC Aubagio) Request (Standard/Basic Option Patient)**: Is teriflunomide (**generic** Aubagio) being requested as a change from **BRAND** Aubagio, Bafiertam, **Brand** Gilenya, Extavia, Mavenclad, Ponvory, or Vumerity to allow the member access to their copay benefit? ❑Yes***** ❑No
   If YES, select medication: ❑**Brand** Aubagio ❑Bafiertam ❑**Brand** Gilenya ❑Extavia ❑Mavenclad ❑Ponvory ❑Vumerity

❒**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Does the patient have any active infections, including tuberculosis (TB)? ❒Yes ❒No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***