



**BlueCross
BlueShield**

Federal Employee Program

BRIUMVI

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: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	<div style="border: 1px solid black; padding: 2px;"> R </div>			Physician Signature:		
PHYSICIAN COMPLETES						

Briumvi

(ublituximab-xiyy)

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

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

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

1. What is the patient's diagnosis?

- ☐ Active Secondary Progressive Multiple Sclerosis (SPMS)
- ☐ Clinically Isolated Syndrome (CIS)
- ☐ Relapsing-Remitting Multiple Sclerosis (RRMS)
- ☐ Relapsing Multiple Sclerosis (MS)
- ☐ Other diagnosis (*please specify*): _____

2. Has the patient been on Briumvi continuously for the last **6 months**, excluding samples? ☐ Yes ☐ No*

***If NO**, please answer the following questions:

- a. Does the patient have advanced, progressive, or severe disease? ☐ Yes ☐ No
- b. Has the patient had ineffective treatment response due to continued clinical relapse to 2 or more MS medications? ☐ Yes ☐ No*
- *If NO**, does the patient have an intolerance or contraindication to two or more MS medications? ☐ Yes ☐ No
- c. Is the patient at risk for Hepatitis B Virus (HBV) infection? ☐ Yes* ☐ No
- *If YES**, has HBV infection been ruled out or has the patient already started treatment for HBV infection? ☐ Yes ☐ No

3. Does the prescriber agree to monitor levels of quantitative serum immunoglobulins? ☐ Yes ☐ No

4. Does the prescriber agree to pre-medicate with a corticosteroid, antihistamine, and/or antipyretic, as clinically indicated? ☐ Yes ☐ No

5. Does the patient have any active infections? ☐ Yes ☐ No

6. Will the patient be given live vaccines or live attenuated vaccines while on Briumvi? ☐ Yes ☐ No

7. **FEMALE Patient:** Is the patient of reproductive potential? ☐ Yes* ☐ No

***If YES**, will the patient be advised to use effective contraception during treatment with Briumvi and for six months after the last dose? ☐ Yes ☐ No

8. Will Briumvi be used in combination with other disease modifying medications for multiple sclerosis? ☐ Yes* ☐ No

***If YES**, please specify the medication: _____

9. Will Briumvi be used in combination with other immune-modulating or immunosuppressive therapies, including immunosuppressant doses of corticosteroids? ☐ Yes* ☐ No

***If YES**, please specify medication: _____



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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:

<p>Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST</p>	<p>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.</p> <p>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.</p>
<p>Phone (4-5 minutes for response)</p>	<p>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.</p> <p>The process over the phone takes on average between 4 and 5 minutes.</p>
<p>Fax (3-5 days for response)</p>	<p>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.</p> <p><u>Please only fax the completed form once as duplicate submissions may delay processing times.</u></p>

**faster...
easier...
better...**

Introducing ePA! Online Prior Authorizations in minutes through **Caremark.com/ePA**. Sign up today!

CVS/caremark 