BlueCross BlueShield Federal Employee Program.

MS INJECTABLE DRUGS 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 Avonex, Betaseron, glatiramer acetate (generic Copaxone), Glatopa, Mayzent, Plegridy, Rebif, Zeposia, dimethyl fumarate (generic Tecfidera), fingolimod (generic Gilenya), and teriflunomide (generic Aubagio) are preferred products. Patients who switch to a preferred product will be eligible for up to 2 copays at no cost in the benefit year.

BRAND Copaxone / Extavia

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

****Non-covered branded medications must go through prior authorization and the formulary exception process**

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

1. **Standard/Basic Option:** Would you like to switch to a preferred product so the patient can access their copay benefit? ***Select answer:***

❑**YES**: Please complete and send back the specified page for the preferred medication now requested:

❑**Avonex / Betaseron / Glatopa / Plegridy / Rebif / glatiramer acetate (generic Copaxone)** (Complete and return Page 3)	❑**fingolimod (generic Gilenya)** (Complete and return Page 6 & 7)	❑**dimethyl fumarate (generic Tecfidera)** (Complete and return Page 9)
❑**teriflunomide (generic Aubagio)** (Complete and return Page 4 & 5)	❑**Mayzent** (Complete and return Page 8)	❑**Zeposia** (Complete and return Pages 10 & 11)

❑**NO**: Please proceed to **PAGE 2**

BlueCross BlueShield Federal Employee Program.

MS INJECTABLE DRUGS PRIOR APPROVAL REQUEST

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PAGE 2 - PHYSICIAN COMPLETES

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

MS Injectable Drugs

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

Please select medication: ❑ **Copaxone (BRAND)** ❑ **Extavia (interferon beta-1b)**

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

*****Non-covered branded medications must go through prior authorization and the formulary exception process**

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

1. **Extavia Request** (**Standard/Basic Option Patient)**: Please answer the following questions:
   a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to glatiramer acetate (**GENERIC** Copaxone)? ***Please select answer below:***
   ❑**Yes** ***(specify result)***: _____
   ❑**No**: Is there a clinical reason for not trying glatiramer acetate (**generic** Copaxone)? ❑Yes***** ❑No
   If YES, please specify: _____
   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to one of the following medications: Avonex, Betaseron, Glatopa, Mayzent, Plegridy, Rebif, Zeposia, dimethyl fumarate (**generic** Tecfidera), fingolimod (**generic** Gilenya), or teriflunomide (**generic** Aubagio)? ***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: _____
   _____

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

5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No

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

PAGE 2

BlueCross BlueShield Federal Employee Program.

MS INJECTABLE DRUGS
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.

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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					

MS Injectables
Preferred Drugs

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

Please select medication:

❑**Avonex (interferon beta-1a)**	❑**glatiramer acetate (generic Copaxone)**	❑**Plegridy (peginterferon beta-1a)**
❑**Betaseron (interferon beta-1b)**	❑**Glatopa (glatiramer acetate)**	❑**Rebif (interferon beta-1a)**

****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

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

2. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No

3. Will this medication be used in combination with another MS disease modifying agent? ❑Yes* ❑No
   If YES, please specify medication: _____

4. **Standard/Basic Option**: Has the patient been on this medication continuously for the last **6 months**, excluding samples? ❑Yes ❑No*
   If NO, is this medication 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

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:
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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 5 FOR ADDITIONAL QUESTIONS

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.

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Attn. Clinical Services
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PAGE 5 - PHYSICIAN COMPLETES

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

BlueCross BlueShield Federal Employee Program.

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

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

Please select medication:

❑Gilenya 0.25mg (fingolimod) **❑Gilenya 0.5mg (fingolimod)** **❑Tascenso ODT (fingolimod)**

****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 capsules/tablets will the patient need for a 90 day supply? _____ capsule(s)/tablet(s) per 90 days

1. **Age 10-17**: **BRAND Gilenya 0.5mg Request (Standard/Basic Option Patient):** Would you like to switch the patient to the preferred product, fingolimod (**generic** Gilenya)? ❑Yes ❑No*

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

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

   ❑**No**: Is there a clinical reason for not trying fingolimod (**generic** Gilenya)? ❑Yes* ❑No

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

2. **Age 18 or Older: BRAND Gilenya 0.5mg Request (Standard/Basic Option Patient):** Would you like to switch the patient to a preferred product: Avonex, Betaseron, Glatopa, Mayzent, Plegridy, Rebif, Zeposia, dimethyl fumarate (**generic** Tecfidera), glatiramer acetate (**generic** Copaxone), or teriflunomide (**generic** Aubagio)? ***Please select answer below:***

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

   ❑**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. Within the last six months, has the patient had a myocardial infarction (MI), unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure that required hospitalization, or Class III/IV heart failure? ❑Yes ❑No

PLEASE PROCEED TO PAGE 7 FOR ADDITIONAL QUESTIONS

BlueCross BlueShield Federal Employee Program.

GILENYA / TASCENSO ODT PRIOR APPROVAL REQUEST

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Fax: 1-877-378-4727

PAGE 7 - PHYSICIAN COMPLETES

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

5. Does the patient have a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sinus syndrome? ❑Yes***** ❑No
   ****If YES***, does the patient have a pacemaker? ❑Yes ❑No

6. Does the patient have significant QTc prolongation (QTc greater than or equal to 500 msec)? ❑Yes ❑No

7. Will the patient be given live vaccines while on this medication? ❑Yes ❑No

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

9. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ❑Yes ❑No*****
   ****If NO***, please answer the following questions:
   a. Will the patient be observed for six hours after the first dose for signs and symptoms of bradycardia with hourly pulse and blood pressure measurements? ❑Yes***** ❑No
      ****If YES***, will the patient be given an electrocardiogram (ECG aka EKG) **BOTH** prior to dosing and at the end of the observation period? ❑Yes ❑No
   b. Has the prescriber reviewed the patient's baseline complete blood count (CBC) including the lymphocyte count? ❑Yes ❑No
   c. Does the patient have a history of uveitis and/or diabetes? ❑Yes***** ❑No
      ****If YES***, will an ophthalmic evaluation of the fundus, including the macula, be completed prior to initiation of therapy? ❑Yes ❑No
   d. **Tascenso ODT Request**: Is the patient unable to swallow or has difficulty swallowing capsules? ❑Yes ❑No
   e. **Age 10-17: Fingolimod (GENERIC Gilenya) Request (Standard/Basic Option)**: Is fingolimod (**generic** Gilenya) being requested as a change from **BRAND** Gilenya 0.5mg to allow the member access to their copay benefit? ❑Yes ❑No
   f. **Age 18 or Older: Fingolimod (GENERIC Gilenya) Request (Standard/Basic Option Patient)**: Is fingolimod (**generic** Gilenya) being requested as a change from **BRAND** Gilenya 0.5mg, Bafiertam, **brand** Aubagio, Extavia, Mavenclad, Ponvory, or Vumerity to allow the member access to their copay benefit? ❑Yes***** ❑No
      ****If YES***, select medication: ❑**Brand** Gilenya 0.5mg ❑Bafiertam ❑**Brand** Aubagio ❑Extavia ❑Mavenclad ❑Ponvory ❑Vumerity

BlueCross BlueShield Federal Employee Program.

MAYZENT
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.

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Prior Approval
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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					

Mayzent (siponimod)

****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 disease multiple sclerosis ❑Relapsing Multiple Sclerosis (MS)
   ❑Clinically Isolated Syndrome (CIS) ❑Relapsing-remitting multiple sclerosis
   ❑Other diagnosis ***(please specify)***: _____
2. Does the patient have a history of any of the following within the past six months: a myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure that required hospitalization, or Class III/IV heart failure? ❑Yes ❑No
3. Does the patient have a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome? ❑Yes* ❑No
   If YES, does the patient have a pacemaker? ❑Yes ❑No
4. Does the patient have significant QTc prolongation (QTc greater than 500 msec)? ❑Yes ❑No
5. Does the patient have severe untreated sleep apnea? ❑Yes ❑No
6. Will the patient be given live vaccines while on Mayzent? ❑Yes ❑No
7. Does the patient have CYP2C9 *1/*3 or CYP2C9 *2/*3 genotype? ***Please select answer below:***
   ❑**Yes**: Please select the genotype and answer the following question:
   a. ❑CYP2C9 *1/*3 **OR** ❑CYP2C9 *2/*3
   b. Does the prescriber agree to not exceed the FDA labeled dose of 1 mg per day? ❑Yes ❑No
   ❑**No**: Does the prescriber agree to not exceed the FDA labeled dose of 2 mg per day? ❑Yes ❑No
8. Will Mayzent be used in combination with other MS disease modifying agents? ❑Yes* ❑No
   If YES, please specify medication: _____
9. Has the patient been on Mayzent continuously for the last **6 months**, excluding samples? ❑Yes ❑No*
   If NO, please answer the following questions:
   a. Has the prescriber reviewed the patient's baseline liver function tests (LFTs), complete blood count (CBC) including lymphocyte count, and electrocardiogram (ECG)? ❑Yes ❑No
   b. Will the patient be monitored for signs and symptoms of bradycardia with hourly pulse and blood pressure measurement after the first dose, as medically indicated? ❑Yes ❑No ❑Not medically indicated
   c. Was the CYP2C9 genotype confirmed prior to starting treatment? ❑Yes* ❑No
      If YES, does the patient have CYP2C9*3/*3 genotype? ❑Yes ❑No
   d. Does the patient have a history of uveitis and/or diabetes? ❑Yes* ❑No
      If YES, will an ophthalmic evaluation of the fundus, including the macula, be completed prior to initiation of therapy? ❑Yes ❑No
   e. **Standard/Basic Option Patient**: Is Mayzent being requested as a change from Bafiertam, **brand** Aubagio, **brand** Gilenya, Extavia, Mavenclad, Ponvory, or Vumerity to allow the member access to their copay benefit? ❑Yes* ❑No
      If YES, select medication: ❑Bafiertam ❑**Brand** Aubagio ❑**Brand** Gilenya ❑Extavia ❑Mavenclad ❑Ponvory ❑Vumerity

BlueCross BlueShield Federal Employee Program.

TECFIDERA
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 provider portion and submit this completed form.

Send completed form to:
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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					

Tecfidera

(dimethyl fumarate)

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

*****Non-covered branded medications must go through prior authorization and the formulary exception process**

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 disease multiple sclerosis
   - ❑Relapsing Multiple Sclerosis (MS)
   - ❑Clinically Isolated Syndrome (CIS)
   - ❑Relapsing-remitting multiple sclerosis
   - ❑Other diagnosis ***(please specify)***: _____

2. Will the patient be given live vaccines while on Tecfidera? ❑Yes ❑No

3. Does the patient have any active serious infections? ❑Yes***** ❑No
   If YES, will treatment be held until the active serious infection is resolved? ❑Yes ❑No

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

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

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   - a. Has the patient had a complete blood count (CBC) within six months of the initiation of therapy? ❑Yes ❑No
   - b. Does the physician agree to obtain a baseline lymphocyte count and monitor annually? ❑Yes ❑No
   - c. Does the physician agree to monitor for signs and symptoms of progressive multifocal leukoencephalopathy (PML) and discontinue the therapy if present? ❑Yes ❑No
   - d. Excluding the starter pack, how many capsules will the patient need for a 90 day supply? _____ cap(s) per 90 days
   - e. **Dimethyl Fumarate (GENERIC Tecfidera) Request (Standard/Basic Option Patient)**: Is dimethyl fumarate (**generic** Tecfidera) being requested as a change from Bafiertam, **brand** Aubagio, **brand** Gilenya, Extavia, Mavenclad, Ponvory, or Vumerity so the member can access their copay benefit? ❑Yes***** ❑No
     If YES, select medication: ❑Bafiertam ❑**Brand** Aubagio ❑**Brand** Gilenya ❑Extavia ❑Mavenclad ❑Ponvory ❑Vumerity

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   - a. Is the physician monitoring the lymphocyte count annually? ❑Yes ❑No
   - b. Does the physician agree to continue to monitor signs and symptoms of progressive multifocal leukoencephalopathy (PML) and discontinue the therapy if present? ❑Yes ❑No
   - c. How many capsules will the patient need for a 90 day supply? _____ capsule(s) per 90 days

BlueCross BlueShield Federal Employee Program.

ZEPOSIA
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					

Zeposia (ozanimod)

****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

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

1. Does the patient have a heart rate greater than or equal to 55 beats per minute? ❑Yes ❑No
2. Does the patient have a history (within the last six months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure? ❑Yes ❑No
3. Does the patient have a presence of Mobitz Type II 2nd degree or 3rd degree AV block, sick sinus syndrome, or sino-atrial block? ❑Yes* ❑No

   If YES, does the patient have a pacemaker? ❑Yes ❑No
4. Does the patient have significant QTc prolongation (males QTcF greater than 450 msec, females greater than 470 msec)? ❑Yes ❑No
5. Does the patient have severe untreated sleep apnea? ❑Yes ❑No
6. Will the patient be given live vaccines while on Zeposia? ❑Yes ❑No
7. What is the patient's diagnosis?

   ❑Active secondary progressive disease multiple sclerosis **OR** ❑Clinically Isolated Syndrome (CIS) **OR**

   ❑Relapsing Multiple Sclerosis (MS) **OR** ❑Relapsing-remitting multiple sclerosis

   a. Has the patient been on Zeposia continuously for the last **6 months**, excluding samples? ❑Yes ❑No*

      If NO, please answer the following questions:

      i. Has the prescriber obtained or will the prescriber obtain baseline live function tests (LFTs), complete blood count (CBC) including lymphocyte count, and electrocardiogram (ECG) evaluations prior to starting therapy? ❑Yes ❑No

      ii. Does the patient have a history of uveitis and/or diabetes? ❑Yes* ❑No

      If YES, will an ophthalmic evaluation of the fundus, including the macula, be completed prior to initiation of therapy? ❑Yes ❑No

      iii. **Standard/Basic Option Patient**: Is Zeposia being requested as a change from Bafiertam, **brand** Aubagio, **brand** Gilenya, Extavia, Mavenclad, Ponvory, or Vumerity to allow the member access to their copay benefit? ❑Yes* ❑No

      If YES, select medication: ❑Bafiertam ❑**Brand** Aubagio ❑**Brand** Gilenya ❑Extavia ❑Mavenclad ❑Ponvory ❑Vumerity

   b. Will Zeposia be used in combination with other MS disease modifying agents? ❑Yes* ❑No

      If YES, please specify medication: _____

PLEASE PROCEED TO PAGE 11 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program.

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PAGE 11 - PHYSICIAN COMPLETES

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

❑Ulcerative Colitis (UC)

a. **Standard/Basic Option**: Humira, Rinvoq, and Stelara (SC) are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year. Would you like to switch the patient to a preferred product? ❑Yes, switch to Humira ❑Yes, switch to Rinvoq ❑Yes, switch to Stelara (SC) ❑No*****

If NO, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **TWO** preferred medications: Humira, Rinvoq, or Stelara (SC)? ***Please select answer below:***

❑**Yes** ***(specify drugs and results)***: _____

_____

❑**No**: Is there a clinical reason for not trying Humira, Rinvoq, or Stelara (SC)? ❑Yes***** ❑No

If YES, please specify: _____

_____

b. Will Zeposia be used in combination with a biologic disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD for ulcerative colitis (e.g., Entyvio, Humira, Simponi, Stelara, Xeljanz)? ❑Yes***** ❑No

If YES, please specify medication: _____

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

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

i. Does the patient have moderately to severely active ulcerative colitis? ❑Yes ❑No

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least **ONE** conventional therapy option? ❑Yes ❑No

iii. Has the prescriber obtained or will the prescriber obtain baseline live function tests (LFTs), complete blood count (CBC) including lymphocyte count, and electrocardiogram (ECG) evaluations prior to starting therapy? ❑Yes ❑No

iv. Does the patient have a history of uveitis and/or diabetes? ❑Yes***** ❑No

If YES, will an ophthalmic evaluation of the fundus, including the macula, be completed prior to initiation of therapy? ❑Yes ❑No

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

i. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No

❑Other diagnosis ***(please specify)***: _____

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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.***