

MAVENCLAD PRIOR APPROVAL REQUEST

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

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.

Patient Inform	ation (required)		Provider Information (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth: Sex: □Male □Female		□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, Glatopa, Mayzent, Plegridy, Rebif, Zeposia, dimethyl fumarate (generic Tecfidera), fingolimod (generic Gilenya), glatiramer acetate (generic Copaxone), and teriflunomide (generic Aubagio) are preferred products. Standard and Basic Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Mavenclad (cladribine)

*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

Standard/Basic Option: Would you like to switch the patient to a preferred product to allow access to their copay benefit? *Select answer* **YES**: Please complete and send back the specified page for the preferred medication now requested:

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

□NO: Please proceed to PAGE 2



BlueShield. MAVENCLAD Federal Employee Program. PRIOR APPROVAL REQUEST

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PAGE 2 - PHYSICIAN COMPLETES					
Patient Name:	DOB:	Patient ID: R			
**Check www.fep		${f d}$ (cladribine) a which medication is part of the patient's benefit			
NOT	E: Form must be complet	ed in its entirety for processing			
Is this request for brand or generic? □Br	and Denoria				
 Standard/Basic Option Patient: Does response to TWO of the following pre- fumarate (generic Tecfidera), fingolin Aubagio)? Please select answer below: 	s the patient have an intole eferred products: Avonex, nod (generic Gilenya), gla	erance or contraindication or have they had an inadequate treatmen Betaseron, Glatopa, Mayzent, Plegridy, Rebif, Zeposia, dimethyl atiramer acetate (generic Copaxone), or teriflunomide (generic			
☐Yes (specify drugs and results):					
■No: Is there a clinical reason for not *If YES, please specify:		ucts? □Yes* □No			
2. What is the patient's diagnosis? □Active Secondary Progressive Multi □Clinically Isolated Syndrome (CIS)	iple Sclerosis (SPMS)				
☐Relapsing Multiple Sclerosis (MS)					
☐Relapsing-Remitting Multiple Sclere	osis (RRMS)				
☐Other diagnosis (<i>please specify</i>):					
 Has the prescriber reviewed baseline li lymphocyte count? □Yes □No 	ver function tests (LFTs)	and complete blood count (CBC) with differential including			
4. FEMALE Patient : Is the patient of re * <i>If YES</i> , is the patient currently pre: * <i>If NO</i> , will the patient be advise the last dose in each treatment co	gnant? ☐Yes ☐No* ed to use effective contract	Yes* □No ception during treatment with Mavenclad and for six months after			
5. MALE Patient: Does the patient have *If YES, will the patient be advised last dose in each treatment course?	to use effective contracep	oductive potential? □Yes* □No otion during treatment with Mavenclad and for six months after the			
6. Does the patient have a current diagno	sis of a malignancy? $\Box Y$	es 🗖 No			
7. Does the patient have a diagnosis of H	IV or an active infection s	such as hepatitis or tuberculosis (TB)? □Yes □No			
8. Will the patient be given live vaccines	while on Mavenclad?	Yes □No			
		r prior to the second treatment course, will the second treatment o 800 cells per microliter? □Yes □No			
 Will Mavenclad be used in combination *If YES, please specify the medical 		e modifying agents? □Yes* □No			
11. What is the patient's current weight?	kg <u>OR</u>	lbs			



BlueShield. AUBAGIO Federal Employee Program. PRIOR APPROVAL REQUEST

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D	Patient Information Pate:	ation (required)		Provider Name:		(required)
	Patient Name:			Specialty:	NPI:	
Date of Birth: Sex: □Male □Female		Office Phone:	Office Fax:			
		Sex. Within	L i cinare	Office Street Address:	Office Tux.	
	treet Address:				1	T .
C	Lity:	State:	Zip:	City:	State:	Zip:
P	atient ID:			Physician Signature:		
]	PHYSICIAN C	COMPLETES		
	For Standard and Basic Option page 22 Zeposia, dimethyl fumarate (gene products. Standard/Basic Option	ric Tecfidera), fin	golimod (generic	Gilenya), and glatiramer aceta	ite (generic Copa	xone) are preferred
			Aubagio (to	eriflunomide)		
		NOTE: Form n	nust be complete	d in its entirety for processing	<u>g</u>	
S	Select <u>Strength</u> (package size is .	30 tablets):	□7mg	□14mg		
**(Check www.fepblue.org/formulary to o	confirm which medi	cation is part of the	patient's benefit		
Is	this request for brand or generic	? □Brand □0	Generic			
Ho	ow many tablets will the patient r	need for a 90 day	supply?	tablet(s) per 90 days		
1.	BRAND Aubagio Request (Statement	JNo*		_		
	teriflunomide (generic Aubaş			ii of have they had all madequ		
	□ No : Is there a clinical reaso * <i>If YES</i> , please spec		_	=	l No	
2.		Plegridy, Rebif, Z baxone)? <i>Please se</i>	eposia, dimethyl elect answer below Betaseron DC rrate (generic Tec	fumarate (generic Tecfidera) : Glatopa), fingolimod (g o gridy □Rebif	eneric Gilenya), or
	□ No : Does the patient have an preferred products? <i>Pleas</i>	intolerance or co	ontraindication or low:		-	onse to any of the
		-	• •	products? □Yes* □No		
3.	What is the patient's diagnosis?					
	☐ Active secondary progressive ☐ Clinically Isolated Syndrome ☐ Other diagnosis (please specify	e multiple scleros (CIS)		lapsing-remitting multiple scl lapsing Multiple Sclerosis (M		
4.	Does the patient have severe her	patic impairment	? □Yes □No)		

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL QUESTIONS

PAGE 3

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Aubagio – FEP MD Fax Form Revised 7/1/2023



BlueShield. AUBAGIO Federal Employee Program. PRIOR APPROVAL REQUEST

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PAGE 4 - PHYSICIAN COMPLETES							
Patient Name: DOB: Patient ID: R							
If YES, is the patient pregna	nt of reproductive potential? □Yes unt? □Yes □No* e advised to use reliable contraceptio		□Yes □No				
6. Will the patient be given live vaco	cines while on Aubagio? Yes N	No					
7. Will the patient be on concomita	ant therapy with Arava (leflunomide)? □Yes □No					
· ·	nation with other MS disease modify cation:	0 0					
□NO – this is INITIATION o	o continuously for the last 6 months , f therapy, please answer the following minase and bilirubin levels been che	ng questions:					
If YES, what was the	ed for latent tuberculosis (TB)? \square Y result of the test positive or negative the patient completed treatment for ly active infections? \square Yes \square No	for TB infection?	□ Positive				
being requested as a char	RIC Aubagio) Request (Standard/Inge from BRAND Aubagio, Bafierta ess to their copay benefit? \(\simeg\)Yes*	ım, Brand Gilenya, Extavia, Mave					
*If YES, select medica	ation: □ Brand Aubagio □Bafierta □Ponvory □Vumerity	nm □Brand Gilenya □ Extav	ia □Mavenclad				
	or CONTINUATION of therapy, ply active infections, including tubercu		n:				



provider portion and submit this completed form.

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

Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 Attn. Clinical Services

Send completed form to: Service Benefit Plan

~	Cililical Selvices
ax:	1-877-378-4727

Patient Information (required) **Provider Information** (required) Date: Provider Name: NPI: Patient Name: Specialty: Date of Birth: □Male ☐Female Office Phone: Office Fax: Sex: Street Address: Office Street Address: City: State: Zip: City: State: Zip: Patient ID: 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: □Gilenva 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* \square 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: \square Yes (specify drug(s) and result(s)): $_$ □No: Is there a clinical reason for not trying the preferred products? □Yes* \square No *If YES, please specify: _ 3. What is the patient's diagnosis? ☐Active secondary progressive multiple sclerosis □Relapsing-remitting multiple sclerosis □Relapsing Multiple Sclerosis (MS) □Clinically Isolated Syndrome (CIS) □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? \square No

PLEASE PROCEED TO PAGE 6 FOR ADDITIONAL QUESTIONS



BlueShield. GILENYA / TASCENSO ODT Federal Employee Program. PRIOR APPROVAL REQUEST

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PAGE 6 - PHYSICIAN COMPLETES						
Patient Name:	DOB:	Patient ID: R				
5. Does the patient have a history or *If YES, does the patient have	•	degree or 3 rd degree AV block or sinus syn	drome? □Yes* □No			
6. Does the patient have significant	QTc prolongation (QTc greater	than or equal to 500 msec)? □Yes □N	О			
7. Will the patient be given live vac	cines while on this medication?	□Yes □No				
8. Will this medication be used in co *If YES, specify medication: _	ombination with other MS disea					
If NO, please answer the follow	wing questions: ed for six hours after the first do	6 months, excluding samples? □Yes □I use for signs and symptoms of bradycardia w	No with hourly pulse and			
* <i>If YES</i> , will the patien observation period?	2	(ECG aka EKG) BOTH prior to dosing and	l at the end of the			
c. Does the patient have a hi	story of uveitis and/or diabetes?	olood count (CBC) including the lymphocyte c □Yes* □No including the macula, be completed prior to it				
d. Tascenso ODT Request:	Is the patient unable to swallow	or has difficulty swallowing capsules?	es □No			
•	• • • • • • • • • • • • • • • • • • • •	Standard/Basic Option): Is fingolimod (geow the member access to their copay benefit	3 / C			
Gilenya) being requested a Ponvory, or Vumerity to a	as a change from BRAND Gilen llow the member access to their	quest (Standard/Basic Option Patient): Is hya 0.5mg, Bafiertam, brand Aubagio, Extatopay benefit? □Yes* □No □Bafiertam □Brand Aubagio □Extavia	via, Mavenclad,			
,,	□Ponvory □Vumerity					



BlueShield. MAYZENT Federal Employee Program. PRIOR APPROVAL REQUEST

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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:	<u> </u>		
City:	State:	Zip:	City:	State:	Zip:	
Patient ID:	1 1		Physician Signature:			
I I	P	HYSICIAN C	OMPLETES			
		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?	P □Brand □G	eneric				
1. What is the patient's diagnosis?						
☐Active secondary progressive	disease multiple	sclerosis	☐Relapsing Multiple Sclere	osis (MS)		
☐Clinically Isolated Syndrome			☐Relapsing-remitting mult	iple sclerosis		
☐Other diagnosis (please speci	, ,					
2. Does the patient have a history of transient ischemic attack, decon						
3. Does the patient have a history or *If YES, does the patient have	presence of Mobit	z Type II 2 nd deg	_			
4. Does the patient have significan	-		than 500 msec)? □Yes □N	Io		
5. Does the patient have severe unt		•				
6. Will the patient be given live va						
7. Does the patient have CYP2C9		-		:		
☐Yes: Please select the genoty						
a. □ CYP2C9 *1/*3						
b. Does the prescriber	agree to not exce	ed the FDA labe	eled dose of 1 mg per day?	lYes □No		
□ No : Does the prescriber agree	to not exceed the	FDA labeled do	ose of 2 mg per day? Yes	□No		
8. Will Mayzent be used in combin *If YES, please specify media		MS disease mod	ifying agents? □Yes* □Ne	0		
9. Has the patient been on Mayzen		the last 6 mont	hs , <u>excluding samples</u> ? □Ye	s □No*		
*If NO, please answer the fol						
a. Has the prescriber revie lymphocyte count, and e			nction tests (LFTs), complete □No	blood count (CB)	C) including	
			bradycardia with hourly pulse One of the bradical of the brad		ire measurement	
c. Was the CYP2C9 genot	ype confirmed pri	ior to starting tre	eatment? □Yes* □No			
*If YES, does the pat	ient have CYP2C	9*3/*3 genotype	? □Yes □No			
d. Does the patient have a	history of uveitis	and/or diabetes?	? □Yes* □No			
* <i>If YES</i> , will an opht therapy? □Yes □		of the fundus, in	ncluding the macula, be comp	leted prior to initi	ation of	
• •		ent being reques	ted as a change from Bafiertan	m, brand Aubagi	o, brand Gilenya,	
			ember access to their copay be			
*If YES, select medica	tion: Bafiertam	□Brand Aub	agio Brand Gilenya E	xtavia	clad □Ponvory	
	□Vumerity					
		~				



Patient Information (required)

BlueShield. MS INJECTABLE DRUGS Federal Employee Program. PRIOR APPROVAL REQUEST

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Provider Information (required)

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Date:			Provider Name:				
Patient Name:	Patient Name:				NPI:		
Date of Birth:	Sex: □Male	Female	Office Phone:		Office Fax:		
Street Address:	Street Address:			Address:			
City:	State:	Zip:	City:	Sta	ite:	Zip:	
Patient ID: R			Physician Sign	ature:			
PHYSICIAN COMPLETES							
			jectables d Products				
	NOTE: Form	must be comple	eted in its entirety	for processing			
Please select medication	n:						
□Avonex (interferon beta-1a) □Glatopa (glatiramer acetate) □Rebif (interferon beta-1a) □Betaseron (interferon beta-1b) □Plegridy (peginterferon beta-1a) □glatiramer acetate (generic Copaxone					: Copaxone)		
**Check www.fepblue.org/fo	rmulary to confirm which me						
Is this request for brand	or generic? Brand □	Generic					
1. What is the patient's	•	• .					
☐ Clinically Isolated	orogressive multiple scler	OSIS					
☐ Relapsing Multiple	•						
☐ Relapsing-remittin	, ,						
☐ Other diagnosis (pa	lease specify):						
2. Will the patient be given	ven live vaccines while o	n 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:							
* <i>If NO</i> , is this med Ponvory, or Vumen	on: Has the patient been on lication being requested a rity to allow the member nedication: Drand Aub Vumerity	as a change from access to their co	brand Aubagio, opay benefit? □Y	Bafiertam, brand ('es* □No	Gilenya, Extavia	a, Mavenclad,	



BlueShield. TECFIDERA Federal Employee Program. PRIOR APPROVAL REQUEST

Service Benefit Plan Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 Attn. Clinical Services

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Attn. Clinical Services Fax: 1-877-378-4727

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P	Patient Inform	nation (required)		Pro	ovider Inf	ormation (required)
Date:				Provider Name:			
Patient Name:			Specialty:		NPI:		
Date of Birth:	Date of Birth: Sex: □Male □Female			Office Phone:		Office Fax:	
Street Address:		<u></u>		Office Street Address	s:	l	
City:		State:	Zip:	City:	S	tate:	Zip:
Patient ID: R	1 1	1 1 1		Physician Signature:			
]	PHYSICIAN C	COMPLETES			
			Tecfi	dera			
			(dimethyl f				
	**Check	www.fepblue.org/for	•	which medication is part	of the patient	's benefit	
***	Non-covered brai	nded medications r	nust go through p	rior authorization and	d the formula	ary exception	process
		NOTE: Form r	nust be complete	d in its entirety for p	rocessing		
Is this request for	r brand or generic	c? □Brand □	Generic				
1. What is the pa	atient's diagnosis	s?					
-	_	ve disease multiple	e sclerosis	☐Relapsing Multi	iple Sclerosi	is (MS)	
	Isolated Syndrom	-		□Relapsing-remit	_		
•	nosis (<i>please spe</i>	, ,					
2. Will the patie	nt be given live v	accines while on	Tecfidera? □Ye	s □No			
3. Does the patie	ent have any activ	ve serious infectio	ns? □Yes* □	No			
•	•			is resolved? □Yes	□No		
4. Will Tecfider	a be used in com	bination with othe	er MS disease mo	difying agents? \(\sigma\)	es* □No		
*If YES, p	lease specify med	lication:					
5. Has the patien	nt been on Tecfid	era continuously f	for the last 6 mor	ths, excluding samp	les? Please s	elect answer b	elow:
		of therapy, please		• •			
	•	•	, ,	six months of the init			s 🗖 No
				count and monitor an	•		
		ee to monitor for s if present? \(\simeg\)Yes		ns of progressive mu	iltifocal leuk	coencephalop	athy (PML) and
d. Exclud	ding the starter pa	ack, how many cap	psules will the pa	tient need for a 90 da	ay supply?_	c	ap(s) per 90 days
Tecfid	era) being reques		om Bafiertam, bi	tandard/Basic Optic and Aubagio, brand			
	•			agio Brand Giler	nva □Exta	via 🗆 Mave	nclad Ponvorv
3	,	□Vumerity			J		J
□ YES – this	s is a PA renewal	for CONTINUA	FION of therapy	, please answer the fo	ollowing que	estions:	
-	• •	ring the lymphocy					
		ee to continue to n rapy if present?		symptoms of progres	ssive multifo	ocal leukoend	ephalopathy (PML)
		ll the patient need		oly? cap	osule(s) per 9	90 days	



BlueShield. ZEPOSIA Federal Employee Program. PRIOR APPROVAL REQUEST

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Patient Information (required) Date:			Provider Information (required) Provider Name:				
Patient Name:				Specialty:		NPI:	
Date of Birth: Sex: □Male □Female		Office Phone:		Office Fax	::		
Street Address:				Office Street Addr	ess:	<u> </u>	
City: State: Zip:			Zip:	City:		State:	Zip:
Patient ID: R				Physician Signatur	re:		
PHYSICIAN COMPLETES							
Is this manual fo		NOTE: Form m	nulary to confirmust be comple	(ozanimod) n which medication is parted in its entirety for	_	t's benefit	
-	r brand or generic		eneric	capsule(s) r	oer 00 daws		
• •	•			${}$ capsule(s) parts per minute? $\square Y_0$			
 Does the patie attack, decomed a	ent have a history apensated heart fair ent have a presence and No pes the patient have significant have severe until be given live valuent's diagnosis? Ondary progressive Multiple Sclerosis e patient been on 2000, please answer Has the prescribe	(within the last six clure requiring hose of Mobitz Type are a pacemaker? Use a pacemaker? Use a pacemaker are decines while on Z decines while deci	months) of medical pitalization, of medical pitalization, of medical pitalization, of medical pitalization, of medical pitalization (males QTcl. pitalization) and medical pit	ayocardial infarction, excluding multiple sclerosis in baseline live	unstable angailure? □Ye. ock, sick sinuec, females greed Syndrome s g samples? function tests	s	, or sino-atrial 70 msec)? □Yes □No
ii	, ,			diabetes? Yes*	•	or to starting	; therapy: a res and
11		an ophthalmic eva		fundus, including the		completed p	rior to initiation of
ii	Gilenya, Extavia	n, Mavenclad, Ponvect medication: ☐ I	ory, or Vumer	Brand Aubagio 🗆 B	er access to th	neir copay be	enefit? □Yes* □No
	=			ase modifying agent		□No	

PLEASE PROCEED TO PAGE 11 FOR ADDITIONAL DIAGNOSES



BlueShield. ZEPOSIA Federal Employee Program. PRIOR APPROVAL REQUEST

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PAGE 11 - PHYSICIAN COMPLETES					
Patient Name:	DOB:	Patient ID: R			
□Ulcerative Colitis (UC)					
product will be eligible		are preferred products. Patients who switch to a preferred tyear. Would you like to switch the patient to a preferred oq \(\subseteq \text{Yes}\), switch to Stelara (SC) \(\subseteq \text{No*}\)			
*If NO, does the par		ication or have they had an inadequate treatment response to			
☐Yes (specify drugs	and results):				
		nvoq, or Stelara (SC)? □Yes* □No			
DMARD for ulcerative	e colitis (e.g., Entyvio, Humira, Simp	e-modifying antirheumatic drug (DMARD) or targeted synthetic ioni, Stelara, Xeljanz)? Yes* No			
c. Has the patient been o	n Zeposia continuously for the last 6	months, excluding samples? Please select answer below:			
	ATION of therapy, please answer the				
i. Does the patient	have moderately to severely active u	llcerative colitis?			
	t have an intolerance or contraindica nal therapy option? \Box Yes \Box No	tion or have they had an inadequate treatment response to at least			
		otain baseline live function tests (LFTs), complete blood count liogram (ECG) evaluations prior to starting therapy? □Yes □No			
iv. Does the patien	nt have a history of uveitis and/or dia	betes? □Yes* □No			
* <i>If YES</i> , wi therapy? □	*	dus, including the macula, be completed prior to initiation of			
		erapy, please answer the following question:			
i. Has the patient'	s condition improved or stabilized wi	th therapy? □Yes □No			
☐Other diagnosis (please spec	<i>ify</i>):				



BlueShield. ZEPOSIA Federal Employee Program. PRIOR APPROVAL REQUEST

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

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.

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.

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