BlueCross BlueShield Federal Employee Program.

MAYZENT
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 physician portion and submit this completed form.

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

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. Mayzent – FEP MD Fax Form Revised 7/1/2023

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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.***