BlueCross BlueShield Federal Employee Program

OCREVUS
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					

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

Please select medication:

❑ **Ocrevus (ocrelizumab)**	❑ **Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq)**

****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 (SPMS)
   - ❑ Clinically isolated syndrome (CIS)
   - ❑ Relapsing multiple sclerosis (RMS)
   - ❑ Relapsing-remitting multiple sclerosis (RRMS)
   - ❑ Primary progressive multiple sclerosis (PPMS)
   - ❑ Other diagnosis ***(please specify):*** _____
2. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***

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

   a. Is the patient at risk for hepatitis B virus (HBV)? ❑Yes* ❑No
   If YES, has HBV infection been ruled out or has the patient already started treatment for HBV infection? ❑Yes ❑No

   b. Does the prescriber agree to monitor immunoglobulins at the beginning, during, and after discontinuation of therapy? ❑Yes ❑No

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

   a. Does the prescriber agree to monitor immunoglobulins during and after discontinuation of therapy? ❑Yes ❑No
3. Does the patient have any active infections? ❑Yes ❑No
4. Will the patient be given live vaccines or live attenuated vaccines while on this therapy? ❑Yes ❑No
5. Will this medication be used in combination with other immune-modulating or immunosuppressive therapies, including immunosuppressant doses of corticosteroids? ❑Yes* ❑No
   If YES, please specify the medication: _____
6. Will this medication be used in combination with other disease modifying medications for MS? ❑Yes* ❑No
   If YES, please specify the medication: _____

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. Ocrevus – FEP MD Fax Form Revised 7/18/2025.