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 provider 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 2 FOR ADDITIONAL QUESTIONS

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 provider 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

PAGE 2 - 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.

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 provider 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

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.***