BlueCross BlueShield Federal Employee Program.

TECFIDERA
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 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

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.

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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.***

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