BlueCross BlueShield Federal Employee Program

MAVENCLAD
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					

Generic 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

Is this request for brand or generic? ***Please select answer below:***

❑ **BRAND Mavenclad** – Please answer the questions on **PAGES 2 – 3**

❑ **GENERIC Mavenclad (cladribine)** – Please answer the questions below (**PAGE 1**)

1. What is the patient's current weight? _____ kg **OR** _____ lbs
2. Is generic Mavenclad (cladribine) being requested as a change from brand Aubagio, brand Gilenya, brand Mavenclad, brand Tecfidera, Bafiertam, Ponvory, or Vumerity? ❑Yes* ❑No
   ***If YES**, please select medication: ❑Brand Aubagio ❑Brand Gilenya ❑Brand Mavenclad ❑Brand Tecfidera ❑Bafiertam ❑Ponvory ❑Vumerity
4. What is the patient's diagnosis?
   ❒Active secondary progressive multiple sclerosis (SPMS)
   ❒Relapsing-remitting multiple sclerosis (RRMS)
   ❒Relapsing multiple sclerosis (MS)
   ❒Other diagnosis ***(please specify)***: _____
5. Will the patient be given live vaccines while on this medication? ❑Yes ❑No
6. Does the prescriber agree to delay the second treatment course until lymphocytes are greater than or equal to 800 cells per microliter? ❑Yes ❑No
7. Has the prescriber reviewed baseline liver function tests (LFTs) and complete blood count (CBC) with differential including lymphocyte count? ❑Yes ❑No
8. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
   ***If YES**, is the patient currently pregnant? ❑Yes ❑No*
   ***If NO**, will the patient be advised to use effective contraception during treatment with Mavenclad and for six months after the last dose in each treatment course? ❑Yes ❑No
9. **MALE Patient:** Does the patient have a female partner of reproductive potential? ❑Yes* ❑No
   ***If YES**, will the patient be advised to use effective contraception during treatment with Mavenclad and for six months after the last dose in each treatment course? ❑Yes ❑No
10. Does the patient have a diagnosis of a clinically isolated syndrome (CIS)? ❑Yes ❑No
11. Does the patient have a current diagnosis of a malignancy? ❑Yes ❑No
12. Does the patient have a diagnosis of HIV or an active infection such as hepatitis or tuberculosis (TB)? ❑Yes ❑No
13. Will Mavenclad be used in combination with other MS disease modifying agents? ❑Yes* ❑No
    ***If YES**, please specify the medication(s): _____

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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:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

All approved requests for BRAND MAVENCLAD are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage. SUBMITTING THE PATIENT'S MEDICAL RECORDS IS REQUIRED.

Brand Mavenclad

***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

DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).

Is this request for brand or generic? ***Please select answer below:***

❑ **GENERIC Mavenclad (cladribine)** – Please answer the questions on **PAGE 1**

❑ **BRAND Mavenclad** – Please answer the questions below (**PAGES 2 – 3**)

1. What is the patient's current weight? _____ kg* **OR** _____ lbs*
   *Please specify the medical record page number(s). **PAGE(s)_____ of _____**

2. **Blue Standard / Blue Basic Patient - *Please answer the questions below:***
   a. Has the patient tried and failed generic Aubagio (teriflunomide), generic Tecfidera (dimethyl fumarate), generic Gilenya (fingolimod), generic Mavenclad (cladribine), Mayzent, or Zeposia? ***Please select answer below:***
      ❑ **YES – Please specify the medication(s) and medical record page number(s).**
      Medication(s): _____ PAGE(s)_____ of _____
      ❑ **NO – The patient has not tried and failed any of these medications.**
   b. Would you like to switch to a preferred medication? The preferred medications are generic Aubagio (teriflunomide), generic Tecfidera (dimethyl fumarate), generic Gilenya (fingolimod), generic Mavenclad (cladribine), Mayzent, or Zeposia.
   Please select answer below:
      ❑ **YES –** Please answer the below questions:
         i. Please select the requested preferred medication: ❑Generic Aubagio 7mg ❑Generic Aubagio 15mg ❑Generic Tecfidera ❑Generic Gilenya ❑Generic Mavenclad ❑Mayzent ❑Zeposia
         ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No
      ❑ **NO –** Do not switch.
      ❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**
      ❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number:**_____
      _____

PLEASE PROCEED TO PAGE 3 FOR ADDITIONAL QUESTIONS

3. **Blue Focus Patient - *Please answer the questions below:***

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. Mavenclad – FEP MD Fax Form Revised 2/27/2026

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

a. This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed.
Please answer below:

❑**Please specify the formulary alternative medication(s) and medical record page number(s):**
PAGE(s)_____ **of** _____ **Formulary alternative medication(s):**_____
_____

❑ **The patient has not tried and failed any formulary alternatives.**

b. Would you like to switch to a preferred medication? The preferred medications are generic Aubagio (teriflunomide), generic Tecfidera (dimethyl fumarate), generic Gilenya (fingolimod), generic Mavenclad (cladribine), Mayzent, or Zeposia. ❑Yes* ❑No

***If YES,** please answer the below questions:

i. Please select the requested preferred medication: ❑Generic Aubagio 7mg ❑Generic Aubagio 15mg ❑Generic Tecfidera ❑Generic Gilenya ❑Generic Mavenclad ❑Mayzent ❑Zeposia

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

4. What is the patient's diagnosis?

❒Active secondary progressive multiple sclerosis (SPMS)**, please specify the medical record page number(s) below:**
PAGE(s)_____ **of** _____

❒Relapsing-remitting multiple sclerosis (RRMS)**, please specify the medical record page number(s) below:**
PAGE(s)_____ **of** _____

❒Relapsing multiple sclerosis (MS)**, please specify the medical record page number(s). PAGE(s)**_____ **of** _____

❒Other diagnosis ***(please specify)***: _____

5. Will the patient be given live vaccines while on this medication? ❑Yes ❑No

6. Does the prescriber agree to delay the second treatment course until lymphocytes are greater than or equal to 800 cells per microliter? ❑Yes ❑No

7. Has the prescriber reviewed baseline liver function tests (LFTs) and complete blood count (CBC) with differential including lymphocyte count? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)**_____ **of** _____

8. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No

If YES, is the patient currently pregnant? ❑Yes ❑No*

If NO, will the patient be advised to use effective contraception during treatment with Mavenclad and for six months after the last dose in each treatment course? ❑Yes ❑No

9. **MALE Patient:** Does the patient have a female partner of reproductive potential? ❑Yes* ❑No

If YES, will the patient be advised to use effective contraception during treatment with Mavenclad and for six months after the last dose in each treatment course? ❑Yes ❑No

10. Does the patient have a diagnosis of a clinically isolated syndrome (CIS)? ❑Yes ❑No

11. Does the patient have a current diagnosis of a malignancy? ❑Yes ❑No

12. Does the patient have a diagnosis of HIV or an active infection such as hepatitis or tuberculosis (TB)? ❑Yes ❑No

13. Will Mavenclad be used in combination with other MS disease modifying agents? ❑Yes* ❑No

If YES, please specify the medication(s): _____