BlueCross BlueShield Federal Employee Program

TECFIDERA / BAFIERTAM / VUMERITY 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

All approved requests for BAFIERTAM, VUMERITY, AND BRAND TECFIDERA 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.

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

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Please select the requested medication below:

❑ **GENERIC Tecfidera (dimethyl fumarate)** – Please answer the questions on **PAGE 2**

❑ **BRAND Tecfidera** – Please answer the questions on **PAGES 3 – 4**

❑ **Bafiertam (monomethyl fumarate)** – Please answer the questions on **PAGES 5 – 6**

❑ **Vumerity (diroximel fumarate)**– Please answer the questions on **PAGES 5 – 6**

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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

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Generic Tecfidera (dimethyl fumarate)

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

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Is generic Tecfidera (dimethyl fumarate) being requested as a change from brand Aubagio, brand Gilenya, brand Tecfidera, Bafiertam, Mavenclad, Ponvory, or Vumerity? ❑Yes* ❑No
   If YES, please select medication: ❑Brand Aubagio ❑Brand Gilenya ❑Brand Tecfidera ❑Bafiertam ❑Mavenclad ❑Ponvory ❑Vumerity
2. What is the patient's diagnosis?
   ❑Active secondary progressive disease multiple sclerosis (SPMS) ❑Relapsing multiple sclerosis (MS)
   ❑Clinically isolated syndrome (CIS) ❑Relapsing-remitting multiple sclerosis (SPMS)
   ❑Other diagnosis ***(please specify)***: _____
3. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
4. 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
5. Will this medication be used in combination with other MS disease modifying agents? ❑Yes* ❑No
   If YES, please specify medication(s): _____
6. 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 prescriber agree to obtain a baseline lymphocyte count and monitor annually? ❑Yes ❑No
   c. Does the prescriber 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

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   a. Does the prescriber agree to monitor the lymphocyte count annually? ❑Yes ❑No
   b. Does the prescriber 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

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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

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Brand Tecfidera

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

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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

1. **Standard/Basic Option Patient - *Please answer the questions below:***
   a. Has the patient tried and failed generic Aubagio (teriflunomide), generic Tecfidera (dimethyl fumarate), generic Gilenya (fingolimod), 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), 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 14mg ❑Generic Tecfidera ❑Generic Gilenya ❑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 4 FOR ADDITIONAL QUESTIONS

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

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), Mayzent, or Zeposia. ❑Yes***** ❑No

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

i. Please select the requested preferred medication: ❑Generic Aubagio 7mg ❑Generic Aubagio 14mg ❑Generic Tecfidera ❑Generic Gilenya ❑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

3. What is the patient's diagnosis? **DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).**

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

❒Clinically isolated syndrome (CIS)**, please specify the medical record page number(s). 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)***: _____

4. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No

5. 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

6. Will this medication be used in combination with other MS disease modifying agents? ❑Yes***** ❑No

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

7. 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

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

b. Does the prescriber agree to obtain a baseline lymphocyte count and monitor annually? ❑Yes ❑No

c. Does the prescriber 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

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

a. Does the prescriber agree to monitor the lymphocyte count annually? ❑Yes ❑No

b. Does the prescriber 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

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.

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 / Bafiertam / Vumerity – FEP MD Fax Form Revised 1/1/2026

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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

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Bafiertam (monomethyl fumarate) / Vumerity (diroximel fumarate)

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

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Please select medication: ❑**Bafiertam (monomethyl fumarate)** ❑**Vumerity (diroximel fumarate)**

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

1. Will the patient need more than 360 capsules every 90 days? ❑Yes***** ❑No
   If YES, please specify the requested quantity: _____ capsules every 90 days

2. **Standard/Basic Option Patient - *Please answer the questions below:***
   a. Has the patient tried and failed generic Aubagio (teriflunomide), generic Tecfidera (dimethyl fumarate), generic Gilenya (fingolimod), 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), 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 14mg ❑Generic Tecfidera ❑Generic Gilenya ❑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 6 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

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

3. **Blue Focus Patient - *Please answer the questions below:***
   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), Mayzent, or Zeposia. ❑Yes***** ❑No
   ****If YES,*** please answer the below questions:
      i. Please select the requested preferred medication: ❑Generic Aubagio 7mg ❑Generic Aubagio 14mg ❑Generic Tecfidera ❑Generic Gilenya ❑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? **DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).**
   ❒Active secondary progressive multiple sclerosis (SPMS)**, please specify the medical record page number(s) below: PAGE(s)_____ of _____**
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   ❒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 therapy? ❑Yes ❑No

6. 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

7. Will this medication be used in combination with other MS disease modifying agents? ❑Yes***** ❑No
   ****If YES***, please specify medication(s): _____

8. Has the patient been on this medication continuously for the last **6 months**, <u>excluding samples</u>? ***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
      ****If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**
      b. Does the prescriber agree to obtain a baseline lymphocyte count and monitor annually? ❑Yes ❑No
      c. Does the prescriber agree to monitor for signs and symptoms of progressive multifocal leukoencephalopathy (PML) and discontinue the therapy if present? ❑Yes ❑No

   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
      a. Does the prescriber agree to monitor the lymphocyte count annually? ❑Yes ❑No
      b. Does the prescriber agree to continue to monitor signs and symptoms of progressive multifocal leukoencephalopathy (PML) and discontinue the therapy if present? ❑Yes ❑No