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					

All approved requests for BRAND GILENYA 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

Please select medication:

❑Gilenya 0.25 mg **❑Gilenya 0.5 mg (fingolimod)** **❑Tascenso ODT (fingolimod)**

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

1. Is this request for brand or generic? ***Please select answer below:***
   - ❑ **BRAND Gilenya** – Please answer the questions on **PAGE 3**
   - ❑ **GENERIC Gilenya (fingolimod)** – Please answer the questions below (**PAGE 1)**.
   - ❑ **Tascenso ODT (fingolimod)** – Please answer the questions below (**PAGE 1)**.

2. **Requests for GENERIC Gilenya (fingolimod):** Is generic Gilenya (fingolimod) 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. Will the patient need more than 90 capsules every 90 days? ❑Yes* ❑No
   ***If YES**, please specify the requested quantity: _____ capsules every 90 days

3. What is the patient's diagnosis?
   - ❒Active secondary progressive multiple sclerosis (SPMS)
   - ❒Relapsing-remitting multiple sclerosis (RRMS)
   - ❒Clinically isolated syndrome (CIS)
   - ❒Relapsing multiple sclerosis (MS)
   - ❒Other diagnosis ***(please specify)*** _____

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

5. 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

6. 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

7. Does the patient have significant QTc prolongation (QTc greater than or equal to 500 msec)? ❑Yes ❑No

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

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

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

9. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ❑Yes ❑No

❒ **NO –** this is **INITIATION** of therapy, 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

b. Will the patient be given an electrocardiogram (ECG aka EKG) **BOTH** prior to dosing and at the end of the observation period? ❑Yes ❑No

c. Has the prescriber reviewed the patient's baseline complete blood count (CBC) including the lymphocyte count? ❑Yes ❑No

d. 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

e. **Tascenso ODT Request**: Is the patient unable to swallow or has difficulty swallowing capsules? ❑Yes ❑No

❒ **YES** – this is a PA renewal for **CONTINUATION** of therapy.

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

Please select medication:

❑**Gilenya 0.25 mg** ❑**Gilenya 0.5 mg (fingolimod)** ❑**Tascenso ODT (fingolimod)**

****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. Is this request for brand or generic? ***Please select answer below:***
   - ❑ **Tascenso ODT (fingolimod)** – Please answer the questions on **PAGE 1**
   - ❑ **GENERIC Gilenya (fingolimod)** – Please answer the questions on **PAGE 1**
   - ❑ **BRAND Gilenya** – Please answer the questions below:

2. **Age 18 or Older: BRAND Gilenya 0.5mg Request (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 ❑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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PAGE 2 - PHYSICIAN COMPLETES

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

3. **Age 10-17**: **BRAND Gilenya 0.5mg Request (Standard/Basic Option Patient):** Has the patient tried and failed generic Gilenya (fingolimod)? ***Please select answer below:***

   ❑ **YES –Please specify the medical record page number(s). PAGE(s)_____ of _____**

   ❑ **NO – The patient has not tried and failed generic Gilenya (fingolimod).** ***Please answer the below questions:***

   a. Would you like to switch to the preferred medication? The preferred medication is generic Gilenya (fingolimod).

   ❑ **YES –** Switch to generic Gilenya (fingolimod).

   ❑ **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:_____**
   _____

4. **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 ❑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

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

6. 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. 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

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

6. 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
   ***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

7. Does the patient have significant QTc prolongation (QTc greater than or equal to 500 msec)? ❑Yes ❑No

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

9. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ❑Yes ❑No

❒ **NO –** this is **INITIATION** of therapy, 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

b. Will the patient be given an electrocardiogram (ECG aka EKG) **BOTH** prior to dosing and at the end of the observation period? ❑Yes ❑No

c. Has the prescriber reviewed the patient's baseline complete blood count (CBC) including the lymphocyte count? ❑Yes* ❑No
   ***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

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

❒ **YES** – this is a PA renewal for **CONTINUATION** of therapy.