Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

TECFIDERA
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Tecfidera	□ 120mg Delayed-Release Capsule □ 240mg Delayed-Release Capsule □ 30 Day Starter Pack			

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

Diagnosis:	Date Diagnosed:

Does the member have relapsing/remitting form of Multiple Sclerosis? □ Yes □ No

Did the member have a recent (within the past 6 months) complete blood count (CBC)? □ Yes □ No
If yes, please indicate date:_____

Does the member have current evidence of active infection? □ Yes □ No

Is the member on concomitant therapy with antineoplastic, immunosuppressive therapy, or immune modulating therapies? □ Yes □ No
If yes, please document in the medication history below.

Is this a REAUTHORIZATION request? □ Yes □ No

If Yes, please submit the following:

- ✓ Documentation showing members disease has stabilized or improved while on therapy
- ✓ Documentation that the member is NOT on concomitant therapy with antineoplastic, immunosuppressive, or immune modulating therapies.
- ✓ Documentation of no active infection
- ✓ Documentation that the member's lymphocyte levels are being monitored annually.
  Date of last test:_____

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Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

History of Medications Used to Treat Above Condition

☐ No other medications have been used to treat this condition

Medication	Strength	Directions	Dates of Therapy		Reason for Discontinuing
			Start	End	

Please provide any additional information which should be considered in the space below: