UPMC HEALTH PLAN

TECFIDERA
Prior Authorization Form

IF THIS IS AN URGENT REQUEST, please call UPMC Health Plan Pharmacy Services.
Otherwise, return completed form to:
UPMC HEALTH PLAN PHARMACY SERVICES PHONE 1-800-396-4139 FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY.
Please complete all sections of this form AND include details of past relevant medical treatment.
Incomplete responses may delay this request.

Office Contact:		**Provider Specialty:**	
Provider First Name:		**Provider Last Name:**	
Provider Phone:		**Provider Fax:**	**Provider NPI #:**
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested:	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for brand-name drugs unless you specifically indicate otherwise.

❑ **New medication** ❑ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, did the member show improvement while on therapy?**	❑**Yes** ❑**No**

Diagnosis:

MEDICAL HISTORY

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 complete below:	

Medication Name	Dose/Strength	Frequency

Please indicate any previously tried therapies below:

Medication Name	Dose/Strength	Frequency

Is this request for a re-authorization? ☐ **Yes** ☐ **No** **If yes, please include the following chart documentation:**

☐ **Documentation showing member's disease has stabilized or improved while on therapy**	☐ **Documentation of no active infection**

☐ **Documentation that the member is <u>NOT</u> on concomitant therapy with antineoplastic, immunosuppressive, or immune modulating therapies**

☐ **Documentation that the member's lymphocyte levels are being monitored annually. Date of test: _____**

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