Tecfidera® (dimethyl fumarate) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: ______________________ Phone: ____________ Fax: ____________

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: / ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: ________ lbs or ________ kgs Height: ________ inches or ________ cms

B. INSURANCE INFORMATION

Aetna Member ID #: ____________________
Group #: ____________________
Insured: ____________________

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ____________ Carrier Name: ____________
Insured: ____________________

Medicare: ☐ Yes ☐ No If yes, provide ID #: ____________ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: ____________

C. PRESCRIBER INFORMATION

First Name:	Last Name:	*(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.		
Address:	City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #: / UPIN:
Provider Email:	Office Contact Name:	Phone:		

Specialty *(Check one)*: ☐ **Neurologist** ☐ **Primary Care** ☐ **Other**: ____________________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ____________
Center Name: ____________
☐ Home Infusion Center Phone: ____________
Agency Name: ____________
☐ Administration code(s) (CPT): ____________
Address: ____________

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: ____________
Name: ____________
Phone: ____________ Fax: ____________
Address: ____________
TIN: ____________ PIN: ____________

E. PRODUCT INFORMATION

Request is for Tecfidera: Dose: ____________ **Frequency:** ____________

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: ____________ Secondary ICD Code: ____________ Other ICD Code: ____________

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For *All* Requests:
Please indicate the type of multiple sclerosis the patient has been diagnosed with:
☐ Relapsing-remitting MS ☐ Secondary-progressive MS ☐ Primary-progressive MS ☐ Progressive-relapsing MS
☐ Yes ☐ No Has the patient discontinued other medications used for treating MS (not including Ampyra)?

For *Initiation* Requests:
☐ Yes ☐ No Has the patient had a recent (within 6 months) complete blood count (CBC)?
→ Please indicate the date of the CBC testing: Date: ____/____/____

For *Continuation* requests:
☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Tecfidera?
(Sampling of Tecfidera does not guarantee coverage under the provisions of the pharmacy benefit)
☐ Yes ☐ No Has the patient had a complete blood count (CBC) completed within the last 12 months?
→ Please indicate the date of the CBC testing: Date: ____/____/____
☐ Yes ☐ No Is there clinical documentation supporting disease stability?
☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: ______________________ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.