Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name		**Name**
ID Number		**Specialty**
D.O.B. ☐Male ☐Female		**Address**
Diagnosis		**City /State/Zip**
Drug Name	**Alymsys, Vegzelma, Zirabev**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**Contact Person Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

❑ Yes ❑ No *If No, a prior authorization is not required through this process*.

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

❑ If primary, continue with question set.

❑ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Criteria Questions:

Please select medication:

❑**Alymsys (bevacizumab-maly)** ❑**Vegzelma (bevacizumab-adcd)** ❑**Zirabev (bevacizumab-bvzr)**

1. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to one of the preferred medications: Avastin **OR** Mvasi? ❑Yes ❑No

2. What is the patient's diagnosis?

❑Cervical cancer

a. Is the cervical cancer metastatic, persistent, or recurrent? ❑Yes ❑No

b. Will the patient be treated with paclitaxel (Taxol)? ❑Yes ❑No

c. Will the patient receive treatment with cisplatin? ❑Yes ❑No*

If NO, will the patient be treated with topotecan (Hycamtin)? ❑Yes ❑No

❑Glioblastoma Multiforme (GBM)

a. Will this medication be used as a single-agent therapy? ❑Yes ❑No

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

If NO, has there been progression of the disease following prior therapy? ❑Yes ❑No

❑Hepatocellular Carcinoma (HCC)

a. Does the patient have unresectable or metastatic hepatocellular carcinoma? ❑Metastatic ❑Unresectable ❑No

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

If NO, has the patient received prior systemic therapy? ❑Yes ❑No

c. Will this medication be given in combination with atezolizumab (Tecentriq)? ❑Yes ❑No

❑Metastatic colorectal cancer

a. Is this medication being used as first-line treatment or second-line treatment? ❑Yes* ***(*If YES, select answer below)*** ❑No

❑**First-line treatment**: Is the patient receiving concurrent IV chemotherapy with 5-Fluorouracil (5-FU)? ❑Yes ❑No

❑**Second-line treatment**: Will the patient be receiving concurrent therapy with fluoropyrimidine-irinotecan chemotherapy, fluoropyrimidine-oxaliplatin chemotherapy, or 5-fluorouracil-based chemotherapy? ❑Yes* ❑No

If YES, select answer: ❑5-Fluorouracil-based chemotherapy ❑Fluoropyrimidine-irinotecan chemotherapy ❑Fluoropyrimidine-oxaliplatin chemotherapy

❑Metastatic renal cell carcinoma

a. Will the patient be receiving concurrent therapy with interferon-alfa? ❑Yes ❑No

❑Non-squamous non-small cell lung cancer

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

If NO, please answer the following questions:

i. Is this medication being used as first-line therapy? ❑Yes ❑No

ii. Is the cancer unresectable, locally advanced, recurrent, or metastatic? ❑Yes ❑No

b. Will the patient be receiving concurrent therapy with carboplatin and paclitaxel? ❑Yes ❑No

❑Epithelial ovarian cancer **OR** ❑Fallopian tube cancer **OR** ❑Primary peritoneal cancer

a. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Is the patient undergoing the initial surgical resection? ❑Yes* ***(*If YES, answer the following questions)*** ❑No

1) Is the cancer a stage III or stage IV disease? ❑Yes ❑No

2) Will this medication be given in combination with carboplatin (Paraplatin) and paclitaxel (Taxol) for up to 6 cycles followed by this medication as a single agent? ❑Yes ❑No

ii. Is the cancer recurrent platinum-resistant or recurrent platinum-sensitive? ❑Yes* ❑Cancer is not recurrent

If YES, please select one of the following:

❑**Recurrent Platinum Resistant:** Will this medication be given concurrently with paclitaxel (Taxol/Onxal), pegylated liposomal doxorubicin (Doxil/Caelyx), or topotecan (Hycamtin)? ❑Yes* ❑No

If YES, please select one of the following below:

❑paclitaxel (Taxol/Onxal) ❑pegylated liposomal doxorubicin (Doxil/Caelyx) ❑topotecan (Hycamtin)

❑**Recurrent Platinum Sensitive**: Will this medication be given in combination with carboplatin (Paraplatin) and paclitaxel (Taxol) followed by this medication as a single agent? ❑Yes ❑No*

If NO, will this medication be given in combination with carboplatin (Paraplatin) and gemcitabine (Gemzar) followed by this medication as a single agent? ❑Yes ❑No

iii. Is the patient's cancer considered to be advanced? ❑Yes* ***(*If YES, answer the following questions)*** ❑No

1) Will this medication be given in combination with olaparib (Lynparza)? ❑Yes ❑No

2) Has the patient had a complete or partial response to platinum-based chemotherapy? ❑Yes* ❑No

If YES, please select one of the following below:

❑Complete response to platinum-based chemotherapy ❑Partial response to platinum-based chemotherapy

iv. Is the cancer associated with homologous recombination deficiency (HRD) positive status? ❑Yes* ❑No

If YES, is the homologous recombination deficiency positive status defined by deleterious or suspected deleterious BRCA mutation or defined by genomic instability? ❑Yes* ***(*If YES, select one of the following below)*** ❑No

❑Deleterious or suspected deleterious BRCA mutation **OR** ❑Genomic instability

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

i. Will this medication be used as single agent therapy after post initial surgical resection? ❑Yes ❑No

ii. Is the cancer recurrent platinum resistant or recurrent platinum sensitive? ❑Yes* ❑Cancer is not recurrent

If YES, please select one of the following:

❑**Recurrent Platinum Resistant**: Will this medication be given concurrently with paclitaxel (Taxol/Onxal), pegylated liposomal doxorubicin (Doxil/Caelyx), or topotecan (Hycamtin)? ❑Yes* ❑No

If YES, please select one of the following below:

❑paclitaxel (Taxol/Onxal) ❑pegylated liposomal doxorubicin (Doxil/Caelyx) ❑topotecan (Hycamtin)

❑**Recurrent Platinum Sensitive**: Will this medication be used as single agent therapy? ❑Yes ❑No

iii. Is the patient's cancer considered to be advanced? ❑Yes* ❑No

If YES, will this medication be given in combination with olaparib (Lynparza)? ❑Yes ❑No

❑Other diagnosis ***(please specify)*****:** _____

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review **(required)**

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

☐ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	**Physician Signature**	**Date**
Step 2: Checklist	☐ Form Completely Filled Out ☐ Provide chart notes	☐ Attach test results
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320**