

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



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.

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PATIENT INFORMATION	PHYSICIAN INFORMATION
<b>Name</b>	<b>Name</b>
<b>ID Number</b>	<b>Specialty</b>
<b>D.O.B.</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Address</b>
<b>Diagnosis</b>	<b>City /State/Zip</b>
<b>Drug Name</b> <b>Avastin</b>	<b>Phone:</b>
<b>Dose and Quantity</b>	<b>Fax:</b>
<b>Directions</b>	<b>NPI</b>
<b>Date of Service(s)</b>	<b>Contact Person</b>
	<b>Contact Person Phone / Ext.</b>

## 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:

1. 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 Avastin be used as a single-agent therapy?  Yes  No
- b. Has the patient been on Avastin 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 Avastin continuously for the last **6 months, excluding samples**?  Yes  No\*  
*\*If NO, has the patient received prior systemic therapy?  Yes  No*
- c. Will Avastin be given in combination with atezolizumab (Tecentriq)?  Yes  No

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Metastatic colorectal cancer

a. Is Avastin 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 Avastin continuously for the last **6 months, excluding samples**?  Yes  No\*

*\*If NO, please answer the following questions:*

i. Is Avastin 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

Ocular disease resulting from intravitreal neovascularization including:

a. Please select one of the following below:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Angioid streaks        | <input type="checkbox"/> Ocular histoplasmosis      | <input type="checkbox"/> Macular edema secondary to retinal vascular occlusion    |
| <input type="checkbox"/> Diabetic macular edema | <input type="checkbox"/> Progressive high myopia    | <input type="checkbox"/> Neovascular (Wet) Age-related Macular Degeneration (AMD) |
| <input type="checkbox"/> Neovascular glaucoma   | <input type="checkbox"/> Retinopathy of prematurity | <input type="checkbox"/> Proliferative diabetic retinopathy                       |

b. Will Avastin be used in combination therapy with other Vascular Endothelial Growth Factor (VEGF) inhibitors for ocular indications?  Yes\*  No

*\*If YES, specify the medication:* \_\_\_\_\_

*\*VEGF Inhibitors: Beovu (brolicizumab-dbl), Eylea (aflibercept), Lucentis (ranibizumab), Susvimo (ranibizumab), Vabysmo (faricimab-svoa)*

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

a. Has the patient been on Avastin 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 Avastin be given in combination with carboplatin (Paraplatin) and paclitaxel (Taxol) for up to 6 cycles followed by Avastin 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 Avastin 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 Avastin be given in combination with carboplatin (Paraplatin) and paclitaxel (Taxol) followed by Avastin as a single agent?  Yes  No\*

*\*If NO, will Avastin be given in combination with carboplatin (Paraplatin) and gemcitabine (Gemzar) followed by Avastin 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 Avastin 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

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**\*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 Avastin 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 Avastin 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 Avastin be used as single agent therapy? Yes No

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

**\*If YES**, will Avastin 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
<b>Step 2:</b> Checklist	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Provide chart notes	<input type="checkbox"/> Attach test results
<b>Step 3:</b> Submit	<b>By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979</b>	<b>By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320</b>

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