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.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name		**Name**
ID Number		**Specialty**
D.O.B.	______/______/________ MM/DD/YYYY ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**Epogen, Procrit, Retacrit**	**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 questionset.
❑ 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: ❑**Epogen (epoetin alfa)** ❑**Procrit (epoetin alfa)** ❑ **Retacrit (epoetin alfa-epbx)**

Note: Approval cannot be given unless all lab values are provided for the diagnosis chosen

1. Is this medication being used in combination with another erythropoiesis stimulating agent (ESA)? ❑Yes* ❑No
   ***If YES**, please specify the medication: ____

2. What is the patient's diagnosis?
   ❑Allogeneic bone marrow transplantation ❑Anemia associated with Hepatitis C (HCV) treatment
   ❑Myelodysplastic syndrome ❑Anemia associated with Rheumatoid Arthritis (RA)/rheumatic disease
   ❑Anemia associated with chronic renal failure
   a. What is the patient's serum ferritin level in nanograms per milliliter (ng/mL)? ____________ ng/mL
   b. Have both the serum ferritin level and hemoglobin level been obtained within the past three months? ❑Yes ❑No
   c. Has the patient been on this medication continuously for the last **4 months**, excluding samples? ***Select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   i. Is the patient on dialysis? ***Please select answer below:***
   ❑**Yes**: What is the patient's *hemoglobin level in grams per deciliter (g/dL)? ____________ g/dL
   ***If hemoglobin level is greater than or equal to 10g/dL**, will the dose be held or reduced until the hemoglobin level is less than 10 grams per deciliter (g/dL)? ❑Yes ❑No
   ❑**No**: What is the patient's *hemoglobin level in grams per deciliter (g/dL)? ____________ g/dL
   ***If hemoglobin level is greater than or equal to 11g/dL**, will the dose be held or reduced until the hemoglobin level is less than 11 grams per deciliter (g/dL)? ❑Yes ❑No
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question(s):
   i. What is the patient's *hemoglobin level in grams per deciliter (g/dL)? ____________ g/dL

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***If hemoglobin level is greater than 11g/dL**, will the dose be held or reduced until the hemoglobin level is less than or equal to 11 grams per deciliter (g/dL)? ❑Yes ❑No

❑Anemia in patients scheduled to undergo elective, non-cardiac, nonvascular surgery
a. What is the patient's hemoglobin level in grams per deciliter (g/dL)? ____________ g/dL

❑Anemia secondary to chemotherapy
- a. Is the patient receiving concomitant myelosuppressive therapy? ❑Yes ❑No
- b. Are there 2 or more additional months of chemotherapy planned for the patient? ❑Yes ❑No
- c. Will the prescriber agree to discontinue use of this medication upon completion of the chemotherapy? ❑Yes ❑No
- d. Does the prescriber agree that transfusions are **NOT** an option for treatment (i.e., end stage organ failure, chronic kidney disease (CKD), and high-risk bacterial infections)? ❑Yes ❑No

❑Anemia secondary to zidovudine-treated Human Immunodeficiency Virus (HIV) patients
a. Are the patient's endogenous serum erythropoietin levels less than or equal to 500 milliunits per milliliter (mU/mL)? ❑Yes ❑No

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

3. **Procrit requests ONLY:** Does the patient have a contraindication or intolerance or have they had an inadequate treatment response to the preferred medication: Retacrit? ❑Yes ❑No

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**

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