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	**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:	❒ **Neupogen**	❒ **Granix**	❒ **Nivestym**	❒ **Releuko**	❒ **Zarxio**

1. What is the patient's diagnosis?

❒Acute myeloid leukemia (AML)

a. Has the patient had induction chemotherapy? ❑Yes ❑No

b. Has the patient had consolidation chemotherapy? ❑Yes ❑No

❒Myelodysplastic syndrome

a. Is the patient neutropenic with recurrent or resistant infections? ❑Yes ❑No

❒Neutropenia

a. What is the cause of the neutropenia?

❒Chemotherapy associated

i. Is the request for prevention of febrile neutropenia following chemotherapy for solid or non-myeloid malignancy? ❑Yes ❑No

ii. Is the patient considered to be at intermediate or high risk? ❑Yes ❑No

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❒Hepatitis C therapy

i. What is the patient's ANC? _____ mm^3

❒AIDS associated ❒Chronic congenital (Kostmann's Syndrome) ❒Cyclic neutropenia

❒Cytomegalovirus-induced ❒Ganciclovir-induced ❒Idiopathic neutropenia

❒Secondary to anti-rejection medications post-transplant

❒Other cause ***(please specify):*** _____

❒Unknown

❒Peripheral blood progenitor cell (PBPC) collection

a. Is the requested medication being used for autologous PBPC mobilization and following transplantation? ❑Yes ❑No

❒Agranulocytosis ❒Aplastic anemia ❒Hairy cell leukemia ❒Hematopoietic stem cell transplantation

❒Hematopoietic syndrome of acute radiation syndrome ❒Umbilical cord stem cell transplantation

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

2. Will the requested medication be used in combination with another granulocyte colony-stimulating factor (G-CSF)? ❑Yes ❑No

3. **For Neupogen(filgrastim), Granix (tbo-filgrastim) or Releuko (filgrastim ayow) requests ONLY:** Has the patient been on treatment with the requested agent continuously for the last **4 months**, excluding samples? ***Please select the answer below:***

❑No – this is **INITIATION** of therapy, please answer the following question:

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to one of the preferred medications: Nivestym or Zarxio? ❑Yes ❑No

❑Yes – this is a PA renewal for **CONTINUATION** of therapy.

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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