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.	_____/_____/_______ MM/DD/YYYY ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**TEGSEDI**	**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:

1. What is the patient's diagnosis?
   - ❑ Polyneuropathy of Hereditary Transthyretin-mediated (hATTR) amyloidosis
   - ❑ Other diagnosis ***(please specify)***: _____
2. Does the patient have a platelet count of greater than or equal to 100,000 cells per microliter? ❑ Yes ❑ No
3. Does the patient have an eGFR greater than or equal to 45 mL/min/1.73m^2? ❑ Yes ❑ No
4. Does the prescriber agree to monitor platelet count, renal function (serum creatinine, eGFR, and urinalysis), and liver function (ALT, AST, and total bilirubin) during therapy with Tegsedi? ❑ Yes ❑No
5. Does the prescriber agree to supplement the patient with the recommended daily allowance of Vitamin A if indicated?
   ❑Yes ❑No
6. Are both the prescriber and patient enrolled in the Tegsedi REMS program? ❑ Yes ❑ No
7. Will Tegsedi be used in combination with another *Prior Authorization (PA) medication for polyneuropathy caused by hATTR amyloidosis? ❑ Yes* ❑No
   ****If YES***, please specify medication: _____
   ****PA Medications: Amvuttra (vutrisiran), Onpattro (patisiran)***
8. Has the patient been on Tegsedi continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:
     a. Has the patient's diagnosis been confirmed by genetic testing or tissue biopsy showing amyloid deposition? ❑ Yes ❑ No
     b. Does the patient have a baseline score using the polyneuropathy disability (PND) scoring tool less than or equal to Stage IIIb?
        ❑ Yes ❑ No*
        ****If NO***, does the patient have a baseline score of Stage 1 or 2 using the FAP scoring tool? ❑ Yes ❑ No
     c. Does the patient have New York Heart Association (NYHA) class 3 or 4 heat failure? ❑ Yes ❑ No
     d. Does the patient have a sensorimotor or autonomic neuropathy not related to hATTR amyloidosis (monoclonal gammopathy, autoimmune disease, etc.)? ❑ Yes ❑ No
     e. Has the patient had a prior liver transplantation? ❑ Yes ❑ No
     f. Is Tegsedi being prescribed by or in consultation with a neurologist, or a specialist in the treatment of the patient's diagnosis?
        ❑Yes ❑No
   - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
     a. Has the patient's condition improved or stabilized with Tegsedi? ❑ 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**