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:

❑**Herceptin (trastuzumab)**	❑**Kanjinti (trastuzumab-anns)**	❑**Ontruzant (trastuzumab-dttb)**
❑**Herzuma (trastuzumab-pkrb)**	❑**Ogivri (trastuzumab-dkst)**	❑ **Trazimera (trastuzumab-qyyp)**

1. What is the patient's diagnosis?

❑Colorectal cancer

a. Is the patient's cancer unresectable or metastatic? ❑Yes ❑No

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

If NO, please answer the following questions:

i. Does the patient have RAS wild-type unresectable or metastatic colorectal cancer, as determined by an FDA-approved test? ❑Yes ❑No

ii. Is the patient's cancer HER2-positive? ❑Yes ❑No

ii. Has the cancer progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy? ❑Yes ❑No

c. Will the requested medication be used in combination with tucatinib (Tukysa)? ❑Yes ❑No

❑HER2 overexpressing breast cancer

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

If NO, has HER-2 protein overexpression or HER-2 gene amplification been confirmed by an FDA-approved test? ❑Yes ❑No

❑HER2 overexpressing metastatic gastric adenocarcinoma

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

If NO, has HER-2 protein overexpression or HER-2 gene amplification been confirmed by an FDA-approved test? ❑Yes ❑No

❑HER2 overexpressing metastatic Gastroesophageal Junction (GEJ) adenocarcinoma

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

If NO, has HER-2 protein overexpression or HER-2 gene amplification been confirmed by an FDA-approved test? ❑Yes ❑No

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

2. Does the prescriber agree to monitor the patient for cardiac function and pulmonary toxicity? ❑Yes ❑No
3. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No

   If YES, will the patient be advised to use effective contraception during treatment with the requested medication and for seven months after the last dose? ❑Yes ❑No
4. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to one of the preferred medications: Kanjinti, Ogivri, or Ontruzant? ❑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**