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	**Xolair**	**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.**

Site of Care:

At what location will the member be receiving the requested medication?
- ❑ Physician's office, home infusion, non-hospital affiliated ambulatory infusion center.
- ❑ Outpatient hospital infusion center. Please provide the name of the infusion center and rationale why the patient must receive this medication in a hospital outpatient setting. ____
  ____
- ❑ Other. Please specify. ____

Criteria Questions:

Has the patient been on Xolair therapy continuously for the last **6 months**, excluding samples? **Please select answer below:**

❑ **NO** - this is **INITIATION** of therapy, please answer the following questions:

1. What is the patient's diagnosis?
   ❑ Asthma
   a. Does the patient have moderate to severe asthma? ❑Yes ❑No
   b. What is the patient's baseline (pre-treatment) serum IgE? ____________ IU/mL ❑Test not completed
   c. Has the patient had inadequate control of asthma symptoms after a minimum of three months of compliant use with a corticosteroid inhaler in combination with a long acting beta$_2$ agonist within the past six months? ❑Yes ❑No*
      ***If NO**, has the patient had inadequate control of asthma symptoms after a minimum of three months of compliant use with a corticosteroid inhaler in combination with a long acting muscarinic antagonist within the past six months?
      ❑Yes ❑No
   d. Does the patient have a positive skin prick test response or a positive RAST response to at least one common allergen?
      ❑Yes ❑No
   e. Will the patient be using another monoclonal antibody for the treatment of asthma? ❑Yes ❑No

- ❑ Chronic idiopathic urticaria
  a. Does the patient have a baseline *urticarial activity score (UAS)? ❑Yes* ❑No
  ***If YES**, please specify the baseline UAS: ____________*
  Urticarial activity score:** **https://www.mdcalc.com/urticaria-activity-score-uas
  b. Has the patient remained symptomatic after at least **TWO** previous trials of H1-antihistamines? ❑Yes ❑No
- ❑ Nasal polyps
  a. Has the patient had an inadequate response, intolerance, or contraindication to a three-month trial of **TWO** nasal corticosteroid sprays (i.e. mometasone, fluticasone, budesonide, or triamcinolone)? ❑Yes ❑No
  b. What is the patient's baseline (pre-treatment) serum IgE? ____________ IU/mL ❑Test not completed
  c. Will Xolair be used as add-on maintenance treatment? ❑Yes ❑No
- ❑ Other diagnosis ***(please specify):*** ____

❑ **YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

1. What is the patient's diagnosis?
   - ❑ Asthma
     a. Has the patient had a break or interruption in treatment? ❑Yes* ❑No
     ***If YES**, please answer the following questions:*
     i. Has the break in treatment been one year or longer? ❑Yes ❑No
     ii. Has the patient's serum IgE level been re-tested since the break in treatment? ❑Yes ❑No
     iii. What is the patient's re-tested serum IgE? ____________ IU/mL ❑Test not completed
     b. Has there been a documented response to therapy and improvement in symptoms? ❑Yes ❑No
     c. Has there been a decrease in the use of rescue medication while on Xolair therapy? ❑Yes ❑No
     d. Will the patient be using another monoclonal antibody for the treatment of asthma? ❑Yes ❑No
   - ❑ Chronic idiopathic urticaria
     a. Has the patient's *urticaria activity score (UAS) decreased, such as improvement in pruritic wheals, hives, and itching? ❑Yes* ❑No
     ***If YES**, please specify the UAS: ____________.*
     Urticarial activity score:** **https://www.mdcalc.com/urticaria-activity-score-uas
   - ❑ Nasal polyps
     a. Has the patient had a break or interruption in treatment? ❑Yes* ❑No
     ***If YES**, please answer the following questions:*
     i. Has the interruption in treatment been one year or longer? ❑Yes ❑No
     ii. Has the patient's serum IgE level been re-tested since the interruption in treatment? ❑Yes ❑No
     iii. What is the patient's re-tested serum IgE? ____________ IU/mL ❑Test not completed
     b. Will Xolair be used as add-on maintenance treatment? ❑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**
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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