

**Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form**



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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Address
Diagnosis	City /State/Zip
Drug Name Aveed	Phone:
Dose and Quantity	Fax:
Directions	NPI
Date of Service(s)	Contact Person
	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:

NOTE: Form must be completed in its entirety for processing

- Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc.) continuously for the **last 4 months, excluding samples**? *Please select answer below:*
 - YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**
 - NO** – this is **INITIATION** of therapy, please answer the following questions below:
- Will the patient be using the requested medication in combination with any other form of testosterone? Yes No
- Aveed Request:** Has the prescribing physician been certified by the Aveed REMS program? Yes No
- What is the patient's diagnosis?
 - Deficiency of Testosterone / Hypogonadism
 - Has the patient had two morning total testosterone levels less than 300 ng/dL on different days? Yes No
 - What is the patient's hematocrit? _____ %
 - Has the patient had a prostatectomy? Yes No*
 - *If NO,* what the patient's baseline Prostate Specific Antigen (PSA)? _____ ng/ml PSA not tested
 - Does the patient have a current diagnosis of prostate cancer? Yes No*
 - *If NO,* does the patient have palpable nodules? Yes No
 - Does the patient have a concurrent diagnosis of benign prostatic hyperplasia (BPH)? Yes* No
 - *If YES,* will the patient be monitored for worsening symptoms of BPH? Yes No
 - Does the patient have a diagnosis of sleep apnea? Yes* No
 - *If YES,* is the patient being treated for their sleep apnea? Yes No
 - Has the patient been evaluated for cardiovascular risks associated with myocardial infarction (MI), angina, and stroke? Yes No
 - Delay in Sexual Development and/or Puberty
 - Will the patient's bone age of the hand and wrist be assessed every six months as determined by radiographic evidence? Yes No
 - Will the patient be tested for liver function every six months? Yes No
 - Will the patient have their hematocrit level monitored every six months? Yes No

- Gender Dysphoria (GD)
 - a. Has the patient met the DSM V criteria for gender dysphoria? Yes No
 - b. Is the patient undergoing a female to male transition? Yes No
 - c. Is this medication being prescribed by an endocrinologist or a prescriber who is experienced in treating this patient or others for gender dysphoria? Yes No
- Other diagnosis (*please specify*): _____

CONTINUATION OF THERAPY TESTOSTERONE INJECTION / IMPLANT (PA RENEWAL)

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc.) continuously for the **last 4 months, excluding samples?** *Please select answer below:*
 - NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
 - YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions below:
2. Will the patient be using the requested medication in combination with any other form of testosterone? Yes No
3. **Aveed Request:** Has the prescribing physician been certified by the Aveed REMS program? Yes No
4. What is the patient's diagnosis?
 - Deficiency of Testosterone / Hypogonadism
 - a. Does the patient have a total testosterone level 800 ng/dL or less? Yes No
 - b. Does the patient have a concurrent diagnosis of benign prostatic hyperplasia (BPH)? Yes* No
 - *If YES, have the symptoms associated with BPH worsened since beginning testosterone therapy?* Yes No
 - c. Will the patient's serum testosterone concentrations be monitored every 12 months? Yes No
 - d. Has the patient had a prostatectomy? Yes No*
 - *If NO, will the patient's Prostate Specific Antigen (PSA) be tested every 12 months?* Yes No
 - e. Will the patient's hematocrit levels be monitored every 12 months? Yes No
 - f. Has the patient been re-evaluated for cardiovascular risks associated with myocardial infarction (MI), angina, and stroke? Yes No
 - Delay in Sexual Development and/or Puberty
 - a. Will the patient's bone age of the hand and wrist be assessed every six months as determined by radiographic evidence? Yes No
 - b. Will the patient be tested for liver function every six months? Yes No
 - c. Will the patient have their hematocrit level monitored every six months? Yes No
 - Gender Dysphoria (GD)
 - a. Is the patient undergoing a female to male transition? Yes No
 - b. Is this medication being prescribed by an endocrinologist or a prescriber who is experienced in treating this patient or others for gender dysphoria? 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	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Provide chart notes	<input type="checkbox"/> 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

Confidentiality notice: This transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this in error, please notify the sender to arrange for the return of this document.