

**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 BEOVU	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:

1. What is the patient's diagnosis?
 Neovascular (wet) Age-related Macular Degeneration (AMD)
 Other diagnosis (*please specify*): _____

2. Does the patient have either an ocular or periocular infection? Yes No

3. Does the patient have active intraocular inflammation? Yes No

4. Will this medication be used with another vascular endothelial growth factor (VEGF) inhibitor? Yes* No

**If YES, please specify: _____*

**VEGF Inhibitors include: Avastin (bevacizumab), Beovu (brolucizumab-dbl), Eylea (aflibercept), Lucentis (ranibizumab), and Macugen (pegaptanib)*

5. Has the patient been on the requested medication continuously for the last **6 months**, excluding samples? *Select answer below:*

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

a. Is there documentation of a baseline visual acuity test? Yes No

YES – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Has the patient demonstrated a *positive clinical response to therapy? Yes No

**Positive Clinical Response include: improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss*

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

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