# 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<br>❑Male ❑Female | **Address** |
| **Diagnosis** | | **City /State/Zip** |
| **Drug Name** | **Beqvez** | **Phone:**<br>**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.**

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**Criteria Questions:**

1. Is the patient assigned female or male at birth? ❑Female ❑Male

2. Does the patient have a diagnosis of hemophilia B? ❑Yes ❑No

3. Does the patient have severe or moderately severe factor IX deficiency (≤ 2% normal circulating factor IX)? ❑Yes ❑No

4. Is the patient currently receiving factor IX prophylaxis therapy? ❑Yes ❑No

5. Does the patient have current or historical life-threatening hemorrhage? ❑Yes ❑No*
   ***If NO**, has the patient experienced repeated, serious spontaneous bleeding episodes? ❑Yes ❑No

6. Has the patient received a liver health assessment including enzyme testing (ALT, AST, ALP, and total bilirubin)? ❑Yes ❑No

7. Has the patient had a hepatic ultrasound and elastography? ❑Yes ❑No

8. Does the patient have neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid as detected by an FDA-approved test? ❑Yes ❑No

9. Does the patient have a history of factor IX inhibitors? ❑Yes ❑No

10. Is the patient factor IX inhibitor positive with screen results of greater than or equal to 0.6 Bethesda Units (BU) using the Nijmegen-Bethesda assay? ❑Yes ❑No

11. Is the patient HIV positive per a serological test and considered not controlled with anti-viral therapy? ❑Yes ❑No

12. Does the patient have an active hepatitis B and/or hepatitis C infection? ❑Yes ❑No

13. Has the patient received prior gene therapy for hemophilia B or under consideration for treatment with another gene therapy for hemophilia B? ❑Yes ❑No

14. Is this medication being prescribed by or recommended by a hematologist or a prescriber who specializes in hemophilia B? ❑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<br>❑ Provide chart notes | ❑ Attach test results |
| **Step 3:** Submit | **By Fax: BCBSM Specialty Pharmacy Mailbox**<br>**1-877-325-5979** | **By Mail: BCBSM Specialty Pharmacy Program**<br>**P.O. Box 312320, Detroit, MI 48231-2320** |

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