

**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 <b>Elelyso</b>	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.**

**Site of Care:**

- A. 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:**

- What is the patient's diagnosis?  
 Gaucher Disease, Type 1  
 Other diagnosis (*please specify*): \_\_\_\_\_
- Will the patient be using Elelyso with other Type 1 Gaucher disease medication(s)?  Yes\*  No  
*\*If YES, please select medication(s) below:*  
 Cerdelga (eliglustat)  Cerezyme (imiglucerase)  VPRIV (velaglucerase alfa)  Zavesca (miglustat)  
 Other medication (*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
<b>Step 2:</b> Checklist	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Provide chart notes	<input type="checkbox"/> Attach test results
<b>Step 3:</b> Submit	<b>By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979</b>	<b>By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320</b>

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