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

Blue Cross Blue Shield Blue Care Network of Michigan

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 ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**Hemlibra**	**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:

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:

1. What is the diagnosis?
   ❑ Hemophilia A (congential factor VIII deficiency)
   ❑ Acquired hemophilia A
   ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the patient's body weight in kilograms? _____kg
4. What is the prescribed dose?
   ❑ **Loading dose (if applicable) -** Quantity and Frequency: _____
   ❑ **Maintenance dose -** Quantity and Frequency: _____
5. Is the requested medication prescribed by or in consultation with a hematologist? ❑ Yes ❑ No
6. Is the request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #9*
7. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)?
   ACTION REQUIRED: If Yes, attach supporting chart note(s). ❑ Yes ❑ No

8. Will the patient use the requested medication for prophylactic use in combination with factor VIII products (e.g., Advate, Adynovate, Eloctate, etc.)? ❑ Yes ❑ No *No further questions*

9. Is the requested mediction being requested for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? ❑ Yes ❑ No

10. What is the patient's baseline factor VIII assay level? _____% activity
If less than 1% - 5%, skip to #13

11. Has the patient had an insufficient response to desmopressin? *If Yes, skip to #13* ❑ Yes ❑ No

12. Is there a clinical reason for not trying desmopressin first? ❑ Yes ❑ No
If Yes, indicate clinical reason _____

13. Will prophylactic use of factor VIII products (e.g., Advate, Adynovate, Eloctate) be discontinued after the first week of starting therapy with the requested medication? ❑ 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 ❑ 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**