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. ☐ Male ☐ Female		**Address**
Diagnosis		**City /State/Zip**
Drug Name	**ILARIS**	**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:

1. What is the patient's diagnosis?
   - ❑ Cold-Induced Auto-inflammatory Syndrome-1 (CIAS1)
   - ❑ Familial Cold Auto-inflammatory Syndrome (FCAS) a form of Cryopyrin-Associated Periodic Syndromes (CAPS)
   - ❑ Familial Mediterranean Fever (FMF)
   - ❑ Hyperimmunoglobulin D Syndrome (HIDS) / Mevalonate Kinase Deficiency (MKD)
   - ❑ Muckle-Wells Syndrome (MWS) a form of Cryopyrin-Associated Periodic Syndromes (CAPS)
   - ❑ Still's Disease, including Adult-Onset Still's Disease (AOSD)
     a. Is the patient's condition considered to be active? ❑Yes ❑No
     b. Has the patient been on Ilaris continuously for the last **6 months**, excluding samples? ❑Yes* ❑No
     If YES, has the patient's condition improved or stabilized while on Ilaris therapy? ❑Yes ❑No
   - ❑ Systemic Juvenile Idiopathic Arthritis (SJIA)
     a. Is the patient's condition considered to be active? ❑Yes ❑No
     b. Has the patient been on Ilaris therapy continuously for the last **6 months**, excluding samples? ❑Yes* ❑No
     If YES, has the patient's condition improved or stabilized while on Ilaris therapy? ❑Yes ❑No
   - ❑ Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)
   - ❑ Other diagnosis (***please specify***): _____

2. Will the patient be concurrently using a Tumor Necrosis Factor (TNF) antagonist? ❑Yes ❑No
3. Will the patient be concurrently using an interleukin-1 receptor antagonist? ❑Yes ❑No
4. Does the patient have evidence of an active infection requiring medical intervention? ❑Yes ❑No
5. Has the patient been on Ilaris therapy continuously for the last **6 months**, excluding samples? ❑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**