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	**ILUMYA**	**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?

❑ Plaque Psoriasis (Ps)

a. Does the patient have moderate to severe plaque psoriasis? ❑Yes ❑No

❑ Other diagnosis ***(please specify)***: _____

2. Does the patient have any active infections, including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No

3. Will the patient be given live vaccines while on Ilumya therapy? ❑Yes ❑No

4. Will Ilumya be used in combination with any other biologic *DMARD or targeted synthetic DMARD? ❑Yes ❑No

DMARD includes: Actemra, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, and Xeljanz

5. Has the patient been receiving Ilumya therapy for at least **4 months** continuously, excluding samples? ***Please select answer below:***

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

a. Does the patient have a contraindication to or have they had either an inadequate response or intolerance to conventional systemic therapy? ***Please select answer below:***

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried conventional systemic therapy

b. Does the patient have a contraindication to or have they had either an inadequate response or intolerance to phototherapy?

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried phototherapy

c. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No

If YES, what was the result of the TB test? ❑Negative ❑Positive*

If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment? ❑Yes ❑No

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

a. Has the patient's condition improved or stabilized with Ilumya therapy? ❑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**