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	**SCIG**	**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:

Please select medication:

❑ **Cutaquig** ❑ **Cuvitru** ❑ **Hizentra** ❑ **Hyqvia** ❑ **Xembify**

1. Has the patient been on the requested medication continuously for the last **6 months**, excluding samples? ***Select answer below:***
   - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer questions on **PAGE 3**
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions below:
     a. Has the patient or their caregiver been instructed on how to monitor for signs and symptoms of thrombosis when self-administering the medication? ❑ Yes ❑ No
     b. Will this medication be given with another immune globulin medication? ❑ Yes ❑ No
        If YES, please specify other medication: _____
     c. What is the patient's diagnosis?
        - ❑ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
          i. Has the patient been treated previously with immunoglobulin therapy (IVIG)? ❑ Yes ❑ No
          ii. Does the prescriber agree to initiate Hizentra one week after the last infusion of IVIG? ❑ Yes ❑ No
          iii. Has the patient had significant improvement in disability and has maintained improvement while on previous IVIG? ❑ Yes ❑ No

❑ Primary Immunodeficiency Disease (PID)
   i. What type of primary immune deficiency does the patient have? ***Please select answer below:***
❑ Agammaglobulinemia **OR** ❑ Severe Combined Immunodeficiency Disease (SCID)
   i. Does the patient have a confirmed diagnosis by genetic or molecular testing? ❑ Yes ❑ No
   ii. Does the patient have a pre-treatment lgG less than 200 mg/dL? ❑ Yes ❑ No
   iii. **SCID Diagnosis**: Does the patient have an absence or very low number of T cells (CD3 T cells less than 300/microliter ❑ Yes ❑ No
   ***If NO**, is there a presence of maternal T cells in the circulation? ❑ Yes ❑ No
❑ Ataxia-telangiectasia, DiGeorge syndrome, Wiskott-Aldrich syndrome or other non-SCID combined immunodeficiency. ***Please answer the following questions:***
   i. Has the patient's diagnosis been confirmed by genetic or molecular testing? ❑ Yes ❑ No
   ii. Does the patient have a documented history of recurrent bacterial and viral infections? ❑ Yes ❑ No
   iii. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑ Yes ❑ No
   iv. What type of PID does the patient have? ***Please select one of the following types below:***
❑ Ataxia-telangiectasia ❑ DiGeorge syndrome ❑ Wiskott-Aldrich syndrome
❑ Other non-SCID combined immunodeficiency ***(please specify):*** _____
❑ Common Variable Immunodeficiency Disease (CVID)
   i. Does the patient have a documented history of recurrent bacterial and viral infections? ❑ Yes ❑ No
   ii. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑ Yes ❑ No
   iii. Have other causes of immune deficiency been excluded including: drug-induced, genetic disorders, infectious diseases such as HIV or malignancy? ❑ Yes ❑ No
   iv. Does the patient have a pre-treatment lgG level of less than 500 mg/dL? ❑ Yes ❑ No
   ***If NO**, does the patient have a pre-treatment lgG equivalent to 2 or more standard deviations below the mean for the age of the patient? ❑ Yes ❑ No
❑ Hypogammaglobulinemia, lgG subclass deficiency, Selective lgA deficiency, Selective lgM deficiency, or Specific antibody deficiency. ***Please answer the following questions:***
   i. Does the patient have a documented history of recurrent bacterial and viral infections? ❑ Yes ❑ No
   ii. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑ Yes ❑ No
   iii. Please select the type of PID and answer the following questions:
❑ **Hypogammaglobulinemia**, please answer the following question:
   i. Does the patient have a pre-treatment lgG level of less than 500 mg/dL? ❑ Yes ❑ No
   ***If NO**, does the patient have a pre-treatment lgG equivalent to 2 or more standard deviations below the mean for the patient's age? ❑ Yes ❑ No
❑ **lgG subclass deficiency**, please answer the following questions:
   i. Does the patient have a pre-treatment lgG1, lgG2, or lgG3 equivalent to 2 or more standard deviations below the mean for the patient's age on at least two separate occasions? ❑ Yes ❑ No
   ii. Does the patient have lgG (total) and lgM levels within normal limits? ❑ Yes ❑ No
   iii. Does the patient have lgA levels within low to normal limits? ❑ Yes ❑ No
❑ **Selective lgA deficiency**, please answer the following question:
   i. Does the patient have a pre-treatment lgA level of less than 7 mg/dL? ❑ Yes ❑ No
   ***If YES**, does the patient have lgG and lgM levels within normal limits? ❑ Yes ❑ No
❑ **Selective lgM deficiency**, please answer the following question:
   i. Does the patient have a pre-treatment lgM level of less than 30 mg/dL? ❑ Yes ❑ No
   ***If YES**, does the patient have lgG and lgA levels within normal limits? ❑ Yes ❑ No
❑ **Specific antibody deficiency**: Does the patient have lgA, lgG, lgM levels within normal limits? ❑ Yes ❑ No
❑ Other diagnosis ***(please specify):*** _____

CONTINUATION OF SCIG IMMUNE GLOBULIN THERAPY (PA RENEWAL)

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑ **Cutaquig**	❑ **Cuvitru**	❑ **Hizentra**	❑ **Hyqvia**	❑ **Xembify**

**Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

Is this request for brand or generic? ❑ Brand ❑ Generic

1. Has the patient been on the requested medication continuously for the last **6 months**, excluding samples? ***Select answer below:***
   ❑ **NO** – this is **INITIATION** of therapy, please answer questions on **PAGE 1**
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions below:

2. What is the patient's diagnosis?

❑ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

a. Have the CIDP symptoms remained stable or improved since changing from previous immunoglobulin therapy (intravenous immunoglobulin)? ❑ Yes ❑ No

b. Is the patient stable on chronic IVIG therapy? ❑ Yes ❑ No
If YES, has the patient been tapered and/or treatment withdrawn to determine whether continued treatment is necessary? ❑ Yes ❑ No

❑ Primary Immunodeficiency Disease (PID), ***select the PID type below:***

❑ Agammaglobulinemia	❑ Ataxia-telangiectasia	❑ Common Variable Immunodeficiency Disease (CVID)
❑ DiGeorge syndrome	❑ Hypogammaglobulinemia	❑ IgG subclass deficiency
❑ Selective lgA deficiency	❑ Selective lgM deficiency	❑ Severe Combined Immunodeficiency Disease (SCID)
❑ Specific antibody deficiency	❑ Wiskott-Aldrich syndrome	

❑ Other non-SCID combined immunodeficiency ***(please specify)***: _____

❑ Other immune deficiency ***(please specify)***: _____

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

3. Will the patient's IgG trough levels be monitored at least yearly and maintained at or above the lower range of normal for the patient's age? ❑ Yes ❑ No

4. Has the patient had a reduction in frequency of bacterial and viral infections that have been documented since therapy with this medication was initiated? ❑ Yes ❑ No

5. Will the prescriber re-evaluate the dose of the medication and reconsider a dose adjustment as needed? ❑ Yes ❑ No

6. Has the patient or their caregiver been instructed on how to monitor for signs and symptoms of thrombosis when self-administering the medication? ❑ Yes ❑ No

7. Will this medication be given with another immune globulin medication? ❑ Yes ❑ No
If YES, please specify other medication: _____

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**