

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



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
<b>Name</b>	<b>Name</b>
<b>ID Number</b>	<b>Specialty</b>
<b>D.O.B.</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Address</b>
<b>Diagnosis</b>	<b>City /State/Zip</b>
<b>Drug Name</b> <b>MEPSEVII</b>	<b>Phone:</b>
<b>Dose and Quantity</b>	<b>Fax:</b>
<b>Directions</b>	<b>NPI</b>
<b>Date of Service(s)</b>	<b>Contact Person</b>
	<b>Contact Person Phone / Ext.</b>

**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?
  - Mucopolysaccharidosis Type VII (MPS VII) (Sly syndrome)
  - Other diagnosis (*please specify*): \_\_\_\_\_
2. Has the patient been on Mepsevii continuously for the last **6 months**, excluding samples?     Yes     No\*
  - \**If NO*, please answer the following question:
    - a. Has the diagnosis of MPS VII been confirmed by genetic testing?     Yes     No\*
      - \**If NO*, are the signs and symptoms of MPS VII such as skeletal abnormalities and decreased level of beta- glucuronidase activity in the blood documented?     Yes     No

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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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