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	**NPLATE**	**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.**

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Hematopoietic syndrome of acute radiation syndrome
   - ❑ Immune Thrombocytopenia (ITP)
     a. Will Nplate be used in combination with another thrombopoietin receptor agent? ❑ Yes ❑ No *****
        ****If NO***, will Nplate be used in combination with Tavalisse (fostamatinib disodium hexahydrate)? ❑ Yes ❑ No
     b. Has the patient been on Nplate continuously for the last **6 months**, excluding samples? ***Please select answer below:***
        - ❑ **NO** - this is **INITIATION** of therapy, please answer the following questions:
          i. **Patients 1-17 Years of Age**: Has the patient had immune thrombocytopenia for at least six months? ❑ Yes ❑ No
          ii. Has the patient experienced an inadequate response or intolerance to corticosteroids, immunoglobulins, or splenectomy? ❑ Yes ❑ No
          iii. Does the patient have a count less than 50,000 platelets per microliter? ❑ Yes ❑ No
        - ❑ **YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
          i. What is the patient's platelet count? ***Please select one of the following below:***
             - ❑ Less than 50,000 platelets per microliter
             - ❑ Between 50,000 to 200,000 platelets per microliter
             - ❑ Greater than 200,000 but less than or equal to 400,000 platelets per microliter ***(answer the following question)***
               1) Does the physician agree that therapy will be adjusted to the minimum platelet count needed to reduce bleeding risk? ❑ Yes ❑ No
             - ❑ Greater than 400,000 platelets per microliter
   - ❑ Other diagnosis ***(please specify):*** _____

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**