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
Name	**Name**
ID Number	**Specialty**
D.O.B. ❑Male ❑Female	**Address**
Diagnosis	**City /State/Zip**
Drug Name	**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.**

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Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Treatment-Resistant Depression
   - ❑ Other diagnosis ***(please specify)***:____
2. Will Spravato be administered under the supervision of a healthcare provider? ❑ Yes ❑ No
3. Will the patient's blood pressure be assessed prior to and after each administration? ❑ Yes ❑ No
4. Will the patient be monitored for sedation and dissociation for at least two hours after administration? ❑ Yes ❑ No
5. Will the patient be monitored for clinical worsening and emergence of suicidal thoughts and behaviors? ❑ Yes ❑ No
6. **FEMALE Patient**: Is the patient pregnant or is the patient of child bearing potential? ❑ Yes ❑ No
   If YES, has the patient been or will the patient be advised about the risks for fetal harm? ❑ Yes ❑ No
7. Will Spravato be used in conjunction with an oral antidepressant? ❑ Yes ❑ No
8. Has the patient been on Spravato continuously for the last **month**, excluding samples?
   Please select answer below:
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:
     a. Was the patient's depression diagnosed using an approved scoring tool, such as the *PHQ-9? ❑ Yes ❑ No
        ****For more information about PHQ-9, please visit:***
        https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/218
     b. Is the healthcare setting, pharmacy, and patient registered with the REMS program? ❑ Yes ❑ No
     c. Has the patient had an inadequate treatment response, developed an intolerance to, or have a contraindication to at least **TWO** different antidepressants? ❑ Yes ❑ No
   - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
     a. Has the patient been evaluated for a positive response to 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**

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