

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



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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Address
Diagnosis	City /State/Zip
Drug Name <b>Synagis</b>	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.**

**Criteria Questions:**

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

- Is Synagis being used to prevent infection caused by Respiratory Syncytial virus (RSV)?  Yes  No
- Will the 1<sup>st</sup> dose be administered 1 month prior to or during the RSV season\*?  Yes  No  
*\*RSV season starts November 1<sup>st</sup> each year. The first dosage could be administered as early as October 1<sup>st</sup>*
- What will the patient's age be (in months) at the start of dosing? \_\_\_\_\_ months
- What was the patient's gestational age (in weeks) at birth? \_\_\_\_\_ weeks
- Please select any of the following diagnoses which apply to the patient:
  - Chronic lung disease (CLD)
    - a. Does the CLD require continued medical support?  Yes  No
  - Hemodynamically significant congenital heart disease (e.g. congestive heart failure or pulmonary hypertension)
  - Congenital airway abnormality that impairs the ability to clear secretions
  - Neuromuscular disorder that decreases the ability to manage airway secretions
  - Other (*please specify*): \_\_\_\_\_
- Is the patient a cardiac transplant or bypass patient?  Yes  No
- Is the patient severely immunocompromised?  Yes  No

*RSV season will be determined by the CDC National Respiratory and Enteric Virus Surveillance System*

*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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